Questions for the Record
"The Honorable Thomas E. Price Nomination Hearing for HHS Secretary"
Hearing Date: January 24, 2017

Questions for the record from Ranking Member Ron Wyden

Brokerage Account Documentation

1. In the hearing, you were asked to reaffirm that trades in your brokerage accounts were controlled by your stock broker and not by yourself.

   Question: Please provide the management and brokerage agreements for all accounts that hold individual health care stocks including but not limited to the Morgan Stanley account labeled Morgan Stanley #1 in your 2015 House of Representatives Financial Disclosure and the Morgan Stanley account labeled Morgan Stanley #2 in your 2015 House of Representatives Financial Disclosure.

   Answer: I previously provided the Senate Finance Committee ("SFC") with substantial information regarding the nature of the brokerage accounts described in this inquiry and have no further information to provide at this time. Additional information regarding Morgan Stanley's management and brokerage policies is also readily available in the public domain.

Management of Shares in Innate Immunotherapeutics

2. As discussed in the disclosure memo, which was made part of the record of the hearing, you purchased shares in Innate Immunotherapeutics in private placements in 2016.

   Question: In what account and in what form were those shares held at the time you filed your financial disclosures, as a nominee, with Federal ethics officials and your response to the Committee's questionnaire? In what account and in what form are those shares currently held? If shares were transferred between accounts, when were they transferred and at whose direction?

   Answer: I previously provided the SFC with substantial information regarding the issues raised in this question. As the Committee is fully aware, the shares of Innate Immunotherapeutics ("Innate") purchased in 2016 through private placement were held with the company in electronic certificate format up until recently. In the process of gathering information to respond to Committee questions (posed on January 17, 2017) in the wake of due diligence meetings with Committee staff, I learned that these electronic certificate holdings have now been transferred to his Wells Fargo Joint Brokerage Account #1. The desire to transfer this holding from electronic certificate form to a brokerage account was discussed during the due diligence meeting with SFC staff. Both the SFC and OGE were appropriately notified of the transfer upon its completion.

Brokerage trades

3. In testimony to the Senate HELP Committee, you stated that you directed your broker to purchases shares in Innate Immunotherapeutics.

   Question: During your time in Congress, have you ever directed your broker to make any other transactions in stock of specific companies? If so, please identify the companies, the date, and volume of the transaction.

   Answer: To the best of my knowledge, I have not undertaken such actions. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Trans-Pacific Partnership Negotiations

4. **Question: Did you or your staff consult with the House Ethics Committee at any time concerning the possibility or appearance of a conflict of interest or other ethics concern arising from your ownership of shares in Innate Immunotherapeutics and your role as a member of the House Ways and Means Committee concerning negotiations related to the Trans-Pacific Partnership, or the receipt of any information that you received in that capacity or as a Member of the House concerning such negotiations.**

   Answer: To the best of my knowledge, neither I nor my staff has had such consultations. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Innate Immunotherapeutics purchases

5. The nominee owns 461,238 shares of Innate Immunotherapeutics Ltd. ("Innate"), a small Australian biopharmaceutical firm developing a multiple sclerosis therapy. The nominee acquired the stock in four separate purchases on January 8, 9 and 23 of 2015 ("2015 tranche"), and in a pair of private stock placements on August 31, 2016 ("2016 tranche"). Regarding Innate:

   a. **Question: Please describe how and when the nominee first learned about Innate.**

      Answer: I previously answered this question for the SFC. I learned about Innate during the course of a conversation in the fall of 2014 with Representative Chris Collins regarding their respective personal backgrounds. I cannot recall the specific date of that conversation. During that exchange, Representative Collins told me that he sat on a number of public company boards including Innate, which was developing a treatment for multiple sclerosis (MS),

   b. **Question: Did the nominee or his staff ever meet or otherwise communicate with current or former employees, directors, consultants or other officials affiliated with Innate. If so, please describe the communication, including who it involved, the date,**

subject, place and form (e.g. in person, by phone of communication.

Answer: I previously answered this question for the SFC.

I communicated with Representative Collins, who is a director of Innate. As noted above, I learned about Innate through a general conversation with him in the fall of 2014. I also communicated with Simon Wilkinson of Innate regarding my interest in participating in the 2016 private placement of company stock. According to Innate's website, Mr. Wilkinson is currently the Managing Director and CEO of Innate.

My Congressional staff has not met or otherwise communicated with current or former employees, directors, consultants or other officials affiliated with Innate.

c. Question: Please describe any communication between the nominee and Congressman Collins regarding Innate Immunotherapy, including the date, subject, place and form.

Answer: I previously answered this question for the SFC.

I had a conversation with Representative Collins in the fall of 2014 that brought Innate, as a company, to my attention. The nature of that conversation did not, however, influence my decision to invest in the company in either 2015 or 2016.

I believe I had subsequent general communications with Representative Collins regarding Innate. I do not have a specific recollection of when those conversations occurred or their substance. Any such communications did not impact my investment decisions, however, because my purchases of Innate stock were based solely on my own research.

d. Question: The nominee bought 400,316 shares in the 2016 tranche in a private stock sale that included two placements at two prices. Please provide the number of shares bought in each placement, and the price at which the shares were bought.

Answer: I previously answered this question for the SFC. I purchased 250,000 shares of Innate in Private Placement 1 at US$0.18/share - the same price offered all participants in this private placement. I purchased 150,613 shares of Innate in Private Placement 2 at US$0.26/share - the same price offered all participants in this private placement.

Zimmer Biomet stock holding

6. **Question: Did you or your staff meet with Zimmer Biomet employees or representatives, including but not limited to lobbyists, executives or board members, between July 14, 2015 and April 1, 2016? If so, please describe the communication,**

including who it involved, the date, subject, place and form (e.g. in person, by phone of communication.

Answer: To the best of my knowledge, neither I nor any members of my staff met with or attended an event with a lobbyist or representative from Zimmer Biomet during the specified dates.

House Ethics Committee consultation

House Rule 3, clause 1, provides that members of the House "shall vote on each question put, unless having a direct personal or pecuniary interest in the event of such question." However, the House Ethics Manual (House Ethics Manual, U.S. House of Representatives Committee on Standards of Official Conduct, 110th Cong, 2d Sess. (2008), pp. 233-37) makes a sharp distinction between, on one hand, voting on the House floor, and, on the other, more active advocacy. The House Ethics Manual states:

The provisions of House Rule 3, clause 1, as discussed in this section apply only to Members voting on the House floor. They do not apply to other actions that Members may normally take on particular matters in connection with their official duties, such as sponsoring legislation, advocating or participating in an action by a House committee, or contacting an executive branch agency. Such actions entail a degree of advocacy above and beyond that involved in voting, and thus a Member's decision on whether to take any such action on a matter that may affect his or her personal financial interests requires added circumspection. Moreover, such actions may implicate the rules and standards, discussed above, that prohibit the use of one's official position for personal gain. Whenever a Member is considering taking any such action on a matter that may affect his or her personal financial interests, the Member should first contact the [Ethics] Committee for guidance.

7. **Question: Before, or any time after, you introduced H.R. 4848, the Healthy Inpatient Procedures Act of 2016 (HIP Act), in the 114th Congress did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in ZimmerBiomet? If so, when?**

   Answer: My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transaction occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

8. **Question: Before, or at any time after, you introduced H.R. 4185, the Protecting Access through Competitive-pricing Transition Act of 2015 (the PACT Act), in the 114th Congress did you consult with the House Ethics Committee concerning the possibility**

of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in healthcare stocks? If so, when?

Answer: My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transactions occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

9. **Question: Before, or at any time after, you introduced H.R. 5400, an Act to amend the Internal Revenue Code of 1986 to make permanent the deduction for income attributable to domestic production activities in Puerto Rico, in the 114th Congress did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in Eli Lilly, Bristol Myers Squibb, and Amgen? If so when?**

   Answer: My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transactions occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

10. **Question: Before, or at any time after, you introduced H.R. 5210, the Patient Access to Durable Medical Equipment (PADME) Act of 2016, in the 114th Congress did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in Blackstone, Inc. or any other company that markets or manufacturers durable medical equipment? If so, when?**

    Answer: My investment accounts were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a Member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Resurgens Orthopaedics

11. **Question: Do you have any financial or business relationship including an equity or ownership stake in Resurgens Orthopaedics, and/or do you derive any financial interest or benefit from the company? If so, please detail the type of financial or business relationship you have, and any income you do or may derive related to Resurgens. In addition, if you answered yes, please describe your plan to divest your financial interest in the company.**

Answer: I have no current financial stake or interest in Resurgens Orthopaedics.

LGBTQ Health Care

12. LGBTQ individuals often experience exceptional barriers to care; health disparities associated with gender identity are partially driven by lower rates of insurance. Under the ACA, the LGBTQ population cannot be excluded from health plans due to pre-existing conditions such as HIV. Discrimination based on sex and gender identity is also prohibited for programs receiving federal funds. Additionally, all insurance plans must offer the same coverage to married same-sex couples as is offered to opposite-sex couples. In terms of national health surveys, the ACA changed data collection requirements to include sexual orientation and gender identity, which supports future advocacy and research.

    Question: Will you maintain health care protections for the LGBTQ community? Please explain.

    Answer: It is essential that healthcare services be available to all people with the highest level of quality, affordability, and respect for their human dignity. If confirmed, I will ensure that HHS follows Congress's lead in defining and enforcing nondiscrimination laws, and that HHS will comply with all statutory and judicial requirements in doing so.

Medicaid and Disability Services

13. Medicaid serves as the primary health insurance program for Americans with disabilities, especially those with limited income. A lack of adequate health and long-term care coverage is often cited as a primary barrier to the ability to live in the community and the ability to succeed in employment. Many of the most important Medicaid-funded services for people with disabilities can be the most expensive. States must offer three of these services: inpatient hospital care, home health care, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). State Medicaid programs currently have the option to cover the remaining services important to Americans with disabilities including: many home-and-community based services; prescription drugs; private duty nursing, physical therapy, occupational therapy; speech, hearing, and language therapy; prosthetic devices; intermediate care facilities; and personal care services.

    Since the enactment of the Americans with Disabilities Act (ADA) in 1990, there has been a concerted effort at the state, federal, and community levels to transform the Medicaid program from institutional-care focused financing mechanism into a comprehensive and flexible community-based long-term services and supports program. Examples of such Congressional efforts can be seen in the Affordable Care Act, which strengthened and expanded the Money Follows the Person program and created the State Balancing Incentive Program and Community First Choice Option.

    a. **Question: How will the Administration ensure Medicaid supports the protections of the Americans with Disabilities Act?**

Answer: The coordination of two complex laws such as Medicaid and the Americans with Disabilities Act requires the close interaction of those who are expert in each. At some level the protections referred to are best supported by allowing states the flexibility to approach them in a way that makes sense for their program, so long as federal requirements are met. As to those federal requirements, there may be a need for close coordination with the Department of Justice or the Equal Employment Opportunity Commission as well as the Department's own Office for Civil Rights.

b. Question: How will you ensure that federal dollars are not used in a way that promotes unnecessary institutionalization of individuals with disabilities?

Answer: Community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in CMS' approach to Home and Community Based Services and the HCBS Settings Rule with a compliance date in March 2019, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances.

c. Question: How will you work to ensure states have sufficient resources to fund home-and-community-based services?

Answer: As with any program or initiative relying on states, the central question for the state is often one of funding. If confirmed, I would work to see that the Department is a helpful resource to the states with respect to these services at least by providing clarity regarding their flexibility, technical assistance and support as needed, and sharing best practices.

d. Question: Will you direct CMS in its approval of waivers to encourage states to expand home-and- community-based services and shift away from waiting lists and institutional care?

Answer: Every state is unique in their specific approach to the provision of services for the population eligible to receive HCBS, and we stand ready to assist states as they develop strategies to meet their particular goals.

Medicaid Equal Access Rule

14. Congressman Price, as you have previously stated, some providers do not accept Medicaid. Studies show that provider payment rates are a leading reason that some providers choose not to participate in Medicaid.

    Recently, the Centers for Medicare & Medicaid Services (CMS) has finalized two major rules to help address this issue—the "equal access" rule and the Medicaid managed care rule

    Question: Congressman Price, given that this is an issue you seem particularly concerned about, will you commit to ensuring successful enforcement of the Medicaid Equal Access rule, the Medicaid managed care rule, and other federal standards that help ensure states set appropriate payment rates as required under the Medicaid statute's equal access provision?

    Answer: If confirmed as Secretary, I will faithfully implement laws written by Congress and the regulations issued by the Department. This includes enforcement action as appropriate. As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them.

Medicare Balance Billing

15. Congressman Price, you have championed legislation to allow providers participating in Medicare to enter into private contracts with Medicare beneficiaries, meaning that those providers would be permitted to balance bill seniors and other Medicare beneficiaries for the difference between what Medicare pays and what the provider decides to charge — potentially putting seniors and other Medicare beneficiaries on the hook for high medical bills. More than 30 years ago, Congress passed legislation to protect against exactly that situation. One study found that out-of-pocket medical spending declined by 9% in Medicare households as a result of these protections.

    Those who want balance billing in Medicare often claim that doctors are fleeing the Medicare program, but evidence demonstrates this is simply not true. Provider participation in Medicare remains strong. In fact, 9 in 10 primary care physicians accept Medicare, and 96 percent of people with Medicare report having regular access to a physician's care. Allowing balance billing would essentially create two tiers of Medicare beneficiaries — those who can afford to access needed care and those who cannot.

    a. **Question: Will you commit to the more than 55 million Americans who rely on Medicare that, if confirmed as HHS Secretary, you will advise the President to veto any legislation that would undermine these decades-old protections and allow providers participating in Medicare to balance bill seniors and other Medicare beneficiaries?**

       Answer: In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be

out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If I am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

b. **Question: Do you believe low- and middle-income seniors can afford to pay more for Medicare services than they currently do?**

Answer: In previous legislation, I have proposed giving our seniors more flexibility within the Medicare Program and providing the opportunity to make decisions with their physicians without interference from Washington. The measure would help ensure that Medicare beneficiaries maintain adequate access to health care professionals by increasing the number of physicians who will accept Medicare patients and addressing physician shortages by attracting new professionals to the field of medicine. In addition, the bill provides safeguards to Medicare beneficiaries. More importantly, it would allow a provider to see a Medicare patient pro-bono or charge minimal cost (below the standard fee schedule) without prosecution.

Raising the Medicare Eligibility Age

16. Congressional Republicans support increasing the Medicare eligibility age from 65 to 67 to generate savings for the federal government. It is well documented that these savings ultimately shift costs to the American people, states, and employers. According to 2014 estimates, increasing the Medicare eligibility age would result in a $11.4 billion shift to individuals, states, and employers. The federal savings would amount to only half of this cost, or $5.7 billion.

    Most Americans retire well before age 67. By age 63, nearly half of the population is no longer working. Advocacy groups argue that increasing the Medicare eligibility age is an across the board benefit cut that undercuts a promise made to working families and seniors more than 50 years ago.

    a. **Question: Would you recommend President Trump veto legislation that would increase the Medicare eligibility age?**

    Answer: In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

b. **Question: If implemented, would federal savings from a higher eligibility age be shifted onto Medicare beneficiaries, states, or employers instead?**

Answer: If such a change is made and the savings do not accrue to beneficiaries and the Trust Fund, then we may be right back where we started without the change. However, the allocation of savings from such a change, whether to the Medicare Trust Fund or to other budgetary priorities, will be a decision for the Congress.

Mental Health

17. As you must know, mental illness is highly prevalent in the United States. Over 43 million adults, just over 18 percent of the population, had any mental illness in 2014. In the past year, over 68 million Americans, representing 20 percent of the population, experienced a psychiatric or substance use disorder.

Medicaid is the country's primary payer for all mental health services and is an important source of funding for mental health services that would otherwise be out of reach for low-income people. Under Medicaid, children and adults with mental illness receive vital services and supports that are not typically covered by private insurance. Medicaid accounted for 25% of all mental health spending in the U.S. in 2014.

Thanks to Medicaid expansion under the Affordable Care Act (ACA), an additional 3.8 million Americans have access to mental health coverage. Furthermore, due to consumer protections under the ACA, it is now required that health insurers provide mental health and substance use disorder services as an essential health benefit.

a. **Question: In your 2017 budget and 2015 reconciliation bill you call for a full out repeal of the Medicaid expansion, do you still support full repeal?**

Answer: This is a matter for the legislative branch to consider. If confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

b. In 2015 you voted to eliminate important coverage protections for Medicaid beneficiaries in alternative benefit plans so they can access the treatment they need.

Question: Do you still support eliminating these protections?

Answer: This is a matter for the legislative branch. I remain committed to making sure health care is affordable and accessible for all Americans. And if confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

c. In your Empowering Patients First Act you call for full repeal of the ACA including important protections such as mental health parity that help to ensure that a person receives the same level of mental health coverage that they would for any physical illness.

Question: Do you still support repeal of these protections?

Answer: I believe it is important that we as a nation make sure that every American has access to the kind of mental health and substance abuse care that they need. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

d. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), which will be your principal advisor as HHS Secretary should you be confirmed, reported that in states that didn't expand Medicaid nearly 2 million low-income adults with mental health and substance use disorders are uninsured.

Question: How do you plan to work with states to expand Medicaid coverage to these individuals?

Answer: Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time working to help identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. If I am confirmed, I will work with CMS and SAMHSA to help the population of uninsured low-income adults with mental health and substance use disorders.

I note that the conversation and focus in these topics has been the question of coverage rather than true access to care. For many Americans, they might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons.

Opioids and Medicaid Expansion

18. In November, I released a report describing the consequences of not adequately funding treatment and prevention services for opioid addiction. However, as we both know, the effects of opioid crisis go far beyond mere statistics. People all across the country end up struggling with opioid addiction simply because they got into a car accident, or had a painful surgery. Medicaid expansion has provided millions of Americans an opportunity to get the treatment they need to get back on their feet.

    a. **Question: Congressman Price, in your 2017 budget you call for ending the Medicaid expansion, can you confirm whether you still support getting rid of the Medicaid expansion?**

Answer: This is a matter for the legislative branch. If confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

b. **Question: In your role as a cabinet Secretary, would you advise the President to veto a bill that repeals the Medicaid expansion?**

Answer: I am committed to making sure all Americans have access to affordable health care that is of the highest quality. Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with states to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. I would encourage anyone to keep this principle front and center in considering any changes to Medicaid, which themselves might well be part of a greater context that further informs the best approach. In the meantime, I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

c. **Question: Would you advise the President to support ending coverage for the 1.6 million Americans struggling with substance use disorders who gained access to coverage for treatment under the Medicaid expansion?**

Answer: It is important that we as a nation make sure that every American has access to the kind of mental health and substance abuse care that they need. If I am confirmed, I am committed to ensure that access is not diminished.

d. **Question: Will you promise that people dealing with opioid addiction will not lose their Medicaid expansion coverage that has provided them with the treatment they need and deserve?**

Answer: Opioid addiction has had a severe and devastating impact to communities and families across the country. If I am confirmed, I am committed to ensure that access to treatments is not diminished and will work with CMS and SAMHSA to help low-income adults with mental health and substance use disorders.

Network Adequacy Rules for Specialty Pharmacies

19. Pharmacy Benefit Managers (PBMs) may or may not own the pharmacies in their pharmacy networks. Recently, PBMs have been criticized for using aggressive tactics to restrict access

to pharmacies that they do not own. If pharmacy networks are narrowed, then individuals will have limited access to pharmacies and necessary medications.

a. I have heard from Oregon pharmacies that pharmacy benefit managers (PBMs) are using aggressive tactics to, in the pharmacies' opinion, restrict access to pharmacies not owned by the PBM.

b. This issue was described in a January 9, 2107 New York Times article: (https://mobile.nytimes.com/2017/01/09/business/specialty-pharmacies-say-benefit-managers-are-squeezing-them out.html?_r=0&referer=https%3A%2F%2Fwww.google.com%2F)

c. I am concerned that if pharmacy networks are narrowed, access to needed medications will be limited.

d. **Question: Can you explain if practices described in the New York Times article are permitted under Medicare Part D and the Exchanges established under the Affordable Care Act (ACA)?**

Answer: Part D plans are required to accept any pharmacy willing to participate in the plan under the terms of its standard contract. Qualified health plans do not have such a requirement though state insurance commissioners may consider such practices in their regulatory oversight.

e. **Question: What minimum standards regarding network adequacy for specialty pharmacies exist for both Part D plans and plans offered on the ACA Exchanges?**

Answer: For Part D plans, network adequacy requirements are set forth in 42 C.F.R. 423.120 and in subregulatory guidance. The requirements vary by the type of drug. For home infusion drugs, they vary by state.
See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Adequate-Access-to-HI-Pharmacies-Rewrite-012610.pdf.

For Qualified Health Plans, network adequacy requirements are set forth at 45 C.F.R. 156.230, 45 C.F.R. 156.122(e), and QHP application and attestation materials, as well as in state laws.

Preventive Care

20. Countless studies have proven that early detection of disease saves lives and improves quality of life. Early detection, through preventive screenings, can save the healthcare system the expense of more costly treatments that may be necessary with a later stage diagnosis. However, early detection of disease is often not possible without preventive screenings, for both acute conditions like cancer and chronic conditions like diabetes. High copays and high

deductibles can be a deterrent to patients utilizing these preventive screenings, regardless of socioeconomic status.

The ACA included a provision requiring private health plans to cover recommended preventive services without any co-payments or cost-sharing. It also added coverage of an annual wellness visit and eliminated cost-sharing for recommended preventive services under the Medicare program.

Question: As HHS Secretary, how will you guarantee that Americans will retain their current level of coverage for preventive screenings and ensure early detection screenings are preserved?

Answer: I would convey to the Medicare population that we look forward to assisting them in getting the care they need and the caregivers that they need too.

As we consider what to do with regards to the Affordable Care Act, my hope is to move in a direction where insurers can offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans.

Spousal Impoverishment Protections

21. In the 1980s, married couples commonly were driven into complete poverty when one spouse developed a need for nursing home care. The couple often had to spend down their joint resources to just a few thousand dollars before Medicaid could provide assistance. Congress addressed this problem in 1988 legislation signed by President Reagan. Beginning in October 1989, the spouse of a nursing home resident has been allowed allocations of income and resources in determining the resident's Medicaid eligibility. These allocations allow the at-home spouse to retain adequate but not lavish amounts of income and savings. To allow for state flexibility, the federal government sets a range for these allocations, and indexes those ranges to inflation. Each state sets its own income allocation and resource allocation, as long as the allocation falls within the federal range.

    Spousal impoverishment protections are mandatory for nursing home residents and were optional for people receiving home and community-based services (HCBS). Due to the Affordable Care Act, people receiving HCBS are also entitled to spousal impoverishment protections.

    a. **Question: Do you support the requirement for state spousal impoverishment protections?**

        Answer: I support the flexibility of states to make decisions about eligibility so that they can ensure the broadest set of people get access to the highest quality care on the budget available to the state. Spousal impoverishment protections allow states to delay or

prevent the impoverishment of spouses lest they too need to be added to the Medicaid rolls.

b. **Question: Should a person be required to receive long-term care in a nursing home in order to protect a spouse from poverty?**

Answer: My hope is that we can move to a system where states can make decisions like this with their population, values, dynamics, and funding in mind.

c. **Question: How will HHS ensure spouses are protected from living in poverty when a loved one reaches a stage of fragility that requires long-term care?**

Answer: I have seen that the best solutions to seemingly intractable problems like this rely on states to find the right approach for that state. If confirmed, I look forward to working with Governors (and Congress) to help states chart their course in this regard.

Women's Health

22. Congressman Price, in the past, when asked whether birth control should have to be covered you've stated said that not a single women has been left behind.

a. **Question: Will you reject any proposals that limit a women's access to contraceptive care or make it cost more for her?**

Answer: Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price.

b. **Question: As a cabinet adviser to the President, will you advise the president to veto any bill that reduces guaranteed access to affordable contraceptive coverage?**

Answer: As we consider what to do with regards to the Affordable Care Act, my hope is to move in a direction where insurers and offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans.

c. **Question: In your hearing last week, you were asked about your vote against the DC Council's efforts to protect employees from being fired for taking birth control. Congressman Price, to clarify for the record, do you or do you not think an**

employer should be able to fire or discriminate against an employee for taking birth control?

Answer: I do not believe so. My vote regarding the DC Council law you mentioned does not relate to this particular issue or question.

d. **Question: Will you advise the president to veto any bill that rips access to care away from hundreds of thousands of women by defunding Planned Parenthood?**

Answer: Deciding whether to sign any particular law, particularly one that involves as many different moving parts as one to replace the Affordable Care Act, inevitably involves considering many competing, complementary, or countervailing issues. If Congress passes a law that makes certain that every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage, that is something I would hope would be strongly considered for signature.

e. **Question: You sponsored the 2015 reconciliation bill (H.R. 3762) that would repeal key components of the Affordable Care Act (ACA) and rescind federal funding for Planned Parenthood for one year. Please provide the names of providers other than Planned Parenthood health centers that H.R. 3762 would prohibit from participating in Medicaid?**

Answer: H.R. 3762 restricts the availability of federal funding to a state for payments to any entity that is a 501(c)(3) tax-exempt organization, is an essential community provider primarily engaged in family planning services and reproductive health; provides abortions other than in cases of rape, incest or life of the mother, and receive a total of more than $350 million under Medicaid in FY 2014.

It should also be noted that H.R. 3762 would increase funding available to the Community Health Center Program (CHC) by $470 million over two years. As I said in my hearing before the Senate Health, Education, Labor, and Pensions (HELP) Committee last week, community health centers are a vital part of the health care delivery system, filling a void in so many areas across the county. We need to do all we can to strengthen them, ensuring they are staffed with the highest quality providers and providing the highest quality care, and look forward to working with you on this if confirmed.

Work Requirements for Medicaid Services

23. Your Budget Plan for 2017 proposes work requirements for so called “able-bodied” adults in order to qualify for Medicaid coverage. Specifically, these individuals must be actively seeking employment or participating in an education or training program in order to qualify for health care coverage under Medicaid.

According to independent evaluations of programs that have imposed work requirements, imposition of work requirements found only modest, short-term increases in employment with families living in deep poverty rising under such programs. The evidence also shows that over the long-term, those in programs with work requirements were as likely to find employment as enrollees in Medicaid programs that did not have strict work requirements.

Question: How do you define an "able-bodied" adult?

Do you support work requirements in order for these "able-bodied" adults to qualify for Medicaid?

Given you're interest in employment, how do you plan on working to support local economies to ensure that those looking for work regardless of income are actually able to obtain jobs?

Answer: One major lesson learned from welfare reform signed into law by President Clinton is that the American people, when given the opportunity, work exceptionally hard. This view is also shared by President Trump and reflected in his commitment to job creation and the dignity of work. Encouraging work allows more families to realize the American dream, earn their success and rise out of poverty. I will faithfully execute any laws passed by Congress to institute work requirements and if given the opportunity to serve I will allow states greater flexibility for determining how to care for their most needy citizens.

AMA Recusal

24. Congressman Price, in your January 11th letter to the Associate General Counsel for Ethics at HHS, you said you would resign from your position as a Delegate of the American Medical Association (AMA) if confirmed as HHS Secretary. You also promised that — for one year after your AMA resignation — you would "not participate personally and substantially in any particular matter involving specific parties in which [you know] the American Medical Association is a party or represents a party, unless [you are] first authorized to participate."

    In 2016 alone, the AMA submitted 21 formal comment letters to HHS and CMS — almost two per month on average — covering a wide range of issues, including, for example, the implementation of the Medicare physician payment reforms in MACRA (the Medicare Access and CHIP Reauthorization Act) and key provisions of last year's Comprehensive Addiction and Recovery Act (CARA).

    a. **Question: In this context, what criteria would you use to determine what constitutes participating "personally and substantially" in a matter?**

    Answer: I view the term "personally and substantially" in the context of its statutory and regulatory definitions. To the extent necessary, I will seek advice from his designated

agency ethics official and other appropriate parties when assessing whether participation in a matter is indeed personal and substantial.

b. **Question: In this context, what criteria would you use to determine whether the level of AMA's involvement means that it is a party or represents a party in a particular matter?**

Answer: I will abide by the actions agreed to in my publicly-available ethics agreement with the Office of Government Ethics, and seek advice (when necessary) from designated agency ethics official and other appropriate persons.

c. **Question: Will you recuse yourself from any matter in which the AMA has submitted formal comments to HHS or CMS?**

Answer: This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in his publicly-available ethics agreement.

d. **Question: For example, will you recuse yourself from any decision-making regarding the implementation of the physician payment reforms in MACRA – given how actively engaged AMA has been with HHS and CMS on that issue?**

Answer: This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly-available ethics agreement.

e. **Question: Will you also recuse yourself from any matter about which the AMA sent correspondence to HHS or CMS?**

Answer: This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly-available ethics agreement.

f. **Question: Do you think an HHS Secretary can effectively do his job if he cannot participate in any of the above described matters?**

Answer: Adherence to all applicable ethics and conflict of interest obligations under federal law is an essential component of being an effective HHS Secretary, and in no way limits the ability of an individual to successfully carry out his or her responsibilities within the Department.

Automatic Cuts to Entitlements

25. The day after you were nominated for HHS Secretary, you rolled out a set of budget process changes that would force automatic cuts to almost all federal programs—including Social Security, Medicare, and Medicaid—if the national debt exceeds targets specified by Congress. If the Trump tax plan is signed into law, but Congress cannot agree on how to pay for its cost of more than $6 trillion over 10 years, your budget process would automatically cut Social Security by $1.7 trillion and Medicare by $1.1 trillion over 10 years. This would cut the average Social Security benefit by $168 per month. President Trump has pledged not to cut Social Security, Medicare, and Medicaid; but your budget process seems to provide a way to cut these programs without President Trump having to sign any specific cuts into law.

    a. **Question: If Congress passed your budget changes today, would you recommend he veto that legislation?**

    Answer: Should the budget pass, I will carefully review the legislation and communicate the health care implications of that budget to the President.

    b. **Question: The sequester, under current law, shields vulnerable populations from across the board cuts. Why do you believe the sequester should be expanded to programs that serve the most vulnerable Americans?**

    Answer: It is my belief that the federal government needs to strengthen mandatory programs if we are going to ensure future generations have access to the programs.

Children's Health Coverage

26. Congressman Price, you once remarked that low-income children already have access to all the health care they need. You've publicly said that you, "know of no study that shows these individuals have no access," and that uninsured children are already treated by doctors and hospitals even though they often do not pay for the care they receive.

    a. **Question: Do you still believe that all children had adequate access to healthcare before the ACA?**

    Answer: Though programs like CHIP have made substantial progress in the availability of health care coverage to children, there has always been more work to do in this regard. I should add that what is most important in this regard is not just that children have coverage but also actual access to care that is affordable and available to them.

    b. **Question: Do you agree that maintaining these coverage gains and not taking a step back on children's health is vitally important?**

    Answer: With regards to health care for children, our goal is to make certain that every single American has access to the coverage they want for themselves and their children

and ensures the individuals and children who lost coverage under the Affordable Care Act get or maintain coverage.

c. **Question: Congressman Price, according to independent reports, repeal of the ACA would mean over 4 million children would become uninsured. As advisor to the President, will you advise the President to veto any bill if the result is fewer children have coverage?**

Answer: Deciding whether to sign any particular law, particularly one that involves as many different moving parts as one to replace the Affordable Care Act, inevitably involves considering many competing, complementary, or countervailing issues. I look forward to working with the Congress to ensure that fewer children having coverage is not one of those tradeoffs, but rather that every single American has access to the coverage they want for themselves and their children and ensures the individuals and children who lost coverage under the Affordable Care Act get or maintain coverage.

Children's Health Insurance Program (CHIP)

27. Today, the bipartisan Children's Health Insurance Program provides 8 million children with access to comprehensive, affordable health care including thousands of children in Oregon's Healthy Kids program. Yet you've publicly referred to CHIP as "government-run socialized medicine" and put forth proposals that would have denied families with access to more affordable care for their children through this successful bipartisan health program.

a. **Question: Congressman Price, in your role as a cabinet Secretary, would you advise the President to support an extension of the Children's Health Insurance Program?**

Answer: It is important that every child has access to high-quality health coverage, and CHIP plays an important role in accomplishing this objective.

b. **Question: Will you commit to ensuring that not a single child under Oregon's Healthy Kids program gets left behind under any CHIP extension?**

Answer: If confirmed as Secretary, my goal would be to ensure that no child in Oregon or anywhere else is left behind. CHIP plays a major role in this, but there is also a need for coordinated family coverage in the private market and employer plans, and giving states the needed flexibility to accomplish this.

c. **Question: As a cabinet-level advisor to the President, will you advise the President to veto any bill that results in coverage being stripped away from a single child in Oregon benefiting from our Healthy Kids program?**

Answer: Deciding whether to sign any particular law inevitably involves considering many competing, complementary, or countervailing issues. I look forward to working with the Congress to ensure that fewer children having coverage is not one of those tradeoffs, but rather that every single child in Oregon and America has access to high-quality care. That means not just having a card, but being able to access the care it covers.

Cost Sharing in Medicaid

28. Your 2017 budget used the Healthy Indiana Plan as an example of an innovative state program that is reducing state Medicaid costs. However, the Healthy Indiana Plan has not worked as intended in some important ways and has created access barriers for some. In fact, studies show that the required premiums for many low-income people depress participation and make it harder for people to access the coverage they need. According to an independent evaluation of the program, thousands of individuals in the program were penalized or kicked off and locked out of coverage under the complicated structure.

    Question: If these types of complicated structures used in a state's Medicaid program is shown to keep eligible people from getting the health care they need, will you disallow it as not meeting the objectives of the Medicaid statute?

    Answer: The Healthy Indiana Plan has long been and continues to be a national model for state-led Medicaid reforms pertaining to the low-income, able-bodied adult population. It is important that Medicaid's design helps its members to transition successfully from the program into commercial health insurance plans, as HIP's consumer-driven approach and underlying incentive structures encourage. HIP members are more engaged with their providers, less reliant on the emergency room, and more satisfied with their coverage than traditional Medicaid members. HIP is achieving Indiana's objective to increase access to consumer-driven coverage as well the broader objectives of the Medicaid program, and I support the use of HIP's reforms in future 1115 demonstration requests by other states.

Delivery System Reform

29. Congressman Price, you have been an outspoken critic of the delivery system reforms included in the Affordable Care Act (ACA), particularly the Center for Medicare and Medicaid Innovation (CMMI) and the movement away from traditional fee-for-service payments for providers and toward value-based payment models such as bundled payments.

    a. **Question: Do you agree that the traditional fee-for-service payment system — in which providers are paid based on volume instead of value — creates incentives for overutilization of health care services?**

    Answer: Our healthcare system is complex, and we cannot attribute overutilization trends to a single cause. For instance, efforts to curb overutilization in emergency rooms

have been unsuccessful. Overutilization is a complex issue that needs to be carefully addressed.

b. **Question: Do you also agree that the successful implementation of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) will require the continued development of value-based payment models?**

Answer: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is built on the principle of encouraging providers to develop Alternative Payment Models (APMs) that can ultimately be adopted by CMS and commercial payers.

c. **Question: Will you commit to supporting the continued development of value-based payment models in Medicare and increasing the percentage of provider payments made through those models?**

Answer: We share the goal of improving Medicare by empowering providers to be creative and develop payment models that best suit the unique needs of their patients to ultimately improve patient care.

Medicare-Medicaid Coordination Office

30. "Dual eligibles" receive benefits under the Medicare and Medicaid programs. Full benefit dual eligibles suffer from serious health care needs including debilitating physical and mental disabilities, often requiring complicated and expensive long-term services and supports. The ACA created the Medicare-Medicaid Coordination Office, also called the Medicare-Medicaid Coordination Office, to coordinate and address the needs of dual eligibles. The office has led federal efforts to improve how programs are delivered to this high need, high cost population.

a. **Question: Will the Administration continue to support the Medicare-Medicaid Coordination Office?**

Answer: If confirmed as Secretary, and if legislation regarding this Office changes, I will work with the CMS Administrator to consider how best to deploy the tremendous resources of CMS against the enormous challenge of ensuring access to the highest quality care for dual beneficiaries. In the meantime, I will implement the law as passed by Congress.

b. **Question: Does the Administration plan to continue the financial alignment demonstration currently underway in several states?**

Answer: Commenting on specific potential models is premature at this point. These models go through a lengthy development and modeling process, as well as internal

review and approval at CMMI and OMB. If confirmed, as HHS Secretary, I plan to work closely with CMS to ensure that CMMI -- after appropriate consultation with Congress, the States, healthcare stakeholders, and Innovation Center staff -- tests innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries.

Federal Data Collection

31. The Department of Health and Human Services (HHS) collected valuable data related to the Affordable Care Act (ACA). This includes rate filings, enrollment data, and analytical reports on the efficacy of the law in different sectors of the health system. Additionally, the ACA invested in the implementation of a new health data collection and analysis strategy. Section 4302 of the Affordable Care Act contains provisions requiring all national federal data collection efforts collect information on race, ethnicity, sex, primary language and disability status. The law also provides HHS the opportunity to collect additional demographic data to further improve our understanding of healthcare disparities.

    a. **Question: Will healthcare data collected by the government continue to be publicly available to promote government transparency?**

    Answer: If confirmed as Secretary, I would implement the law regarding these topics as written and passed by the Congress.

    b. **Question: Will healthcare data continue to require the collection of information on race, ethnicity, sex, primary language, and disability status?**

    Answer: If confirmed as Secretary, I would implement the law regarding these topics as written and passed by the Congress, including with respect to the data points required to be collected.

    c. **Question: How does CMS plan to leverage this data to address health disparities?**

    Answer: Any data that can inform CMS' approach to understanding where people's needs are not being met will help us understand how best to move towards a system where every single American has access to the coverage they want for themselves.

Ban on Health Agency Communications

32. News reports on January 24th indicate that Trump administration officials have issued what amounts to a gag order essentially muzzling external communications by employees of the Department of Health and Human Services (HHS) and the National Institutes of Health between now and February 3. This ban on external communications reportedly includes correspondence with public officials including members of Congress as well as press releases and social media posts.

a. **What communications are covered by the Trump Administration's restriction of external communications?**

b. **Are there any exceptions allowed for releases of information about matters of public health or safety?**

c. **If a public health or safety matter arises between now and February 3, will the agencies be prevented from communicating with public officials or the general public about these matters?**

d. **Under what circumstances would external communications be allowed?**

e. **Who within the Department is authorized to allow communications in a public health or safety situation or otherwise? Please provide the criteria that has been developed to determine if and when external communications are permitted.**

f. **What impact will this restriction have on whistleblowers who are exercising rights protected by law?**

g. **What is the reason for this action?**

h. **Is it possible the restriction will be extended beyond February 3? Under what circumstances could it be extended?**

i. **Does the restriction apply to federal employees' personal use of social media or only use of official agency accounts?**

j. **Will the restriction prevent HHS employees from responding to outstanding questions from Members of Congress including letters or other communications awaiting answers? If so, when will such questions be answered?**

k. **Will questions submitted by members of the Finance Committee be answered in a timely manner and in any case before February 3 notwithstanding the restriction on external communications?**

Answer: The Acting Secretary Memo to Department of Health and Human Services operating and staff division heads is straightforward and consistent with Chief of Staff Memo issued on behalf of President Trump with regard to regulatory review of new or pending regulations and guidance. As noted in the HHS memo, the purpose of the directive is to ensure "President Trump's appointees and designees have the opportunity to review and approve any new or pending regulations or guidance documents." Furthermore, the Chief of Staff memo provides explicit exceptions for "emergency situations or other urgent circumstances relating to health, safety, financial, or national security matter..." This request is standard for a new Administration. With regard to correspondence to public officials, such as Members of Congress, the memo outlines a clear and expedited process for adequate review and is by no means intended to impede

the agencies or staff divisions from continuing their important work on behalf of the American people, including routine constituent service communications.

Cost-Sharing Reductions

33. Under the Affordable Care Act, individuals and families with incomes between the federal poverty level and 250 percent of the poverty level are eligible for cost-sharing reductions (CSRs) if they are eligible for a premium tax credit and purchase a silver plan through the health insurance exchange. The cost-sharing reductions reduce the deductibles, copayments, and other out-of-pocket costs for these lower- and moderate-income Americans.

    In *House v. Burwell*, House Republicans challenged the legality of federal funding of CSR subsidies. In a May 2016 ruling, U.S. District Judge Rosemary Collyer ruled in favor of the House Republicans, although she stayed implementation of the ruling. The previous Administration appealed the decision, but the case was stayed until after the 2016 presidential election.

    a. **Question: If confirmed as HHS Secretary, will you recommend that the Administration continue to reimburse insurers for the cost-sharing reductions that reduce deductibles, copayments and other out-of-pocket costs for lower- and moderate-income Americans?**

    Answer: The Agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

    b. **Question: If confirmed as HHS Secretary, will you recommend that the Administration protect the federal government's authority to make payments for cost-sharing reductions, which was challenged in *House v. Burwell*, and move forward with its appeal of the lower court's ruling?**

    Answer: The Agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

    c. **Question: If confirmed as HHS Secretary, will you recommend that the Administration seek an appropriation from Congress for the cost-sharing reductions?**

    Answer: It will be up to the President and Congress to determine the appropriate policy on this issue. My job, if confirmed, would be to faithfully execute that law.

Risk Corridor Payments

34. The Affordable Care Act's temporary risk corridor program was intended to promote accurate premiums in the early years of the exchanges (2014 through 2016) by cushioning

insurers from extreme gains and losses. It was modeled after the Medicare Part D prescription drug program's successful risk corridor program. The federal government currently owes insurers approximately $8.3 billion under the risk corridor program to offset losses from 2014 and 2015. This is largely due to a rider attached to the 2015 and 2016 appropriations bills requiring the risk corridor program to be revenue neutral, meaning that the Centers for Medicare & Medicaid Services (CMS) can only pay out funds under the program that it collected under the program.

Under the previous Administration, HHS and CMS acknowledged that risk corridor payments are an obligation of the government and that full payment must be made to insurers. The Department of Justice defended the lawsuits brought by insurers for the full risk corridor payments, but also expressed a willingness to engage in settlement discussions.

a. **Question: If confirmed as HHS Secretary, will you also acknowledge that risk corridor payments are an obligation of the government and that full payment must be made to insurers?**

   Answer: The Agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

b. **Question: If confirmed as HHS Secretary, will you recommend that the Administration engage in settlement discussions with insurers on overdue risk corridor payments?**

   Answer: The Agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

Gender Rating

35. Before the Affordable Care Act, insurance companies were able to charge women more for their health insurance compared to men. This practice was widespread as 92 percent of the best-selling plans on the individual market used gender rating in setting their premiums. This cost women approximately $1 billion in additional costs each year that men did not have to pay.

    Question: Do you believe that insurance companies should be required to charge men and women the same rate for premiums?

    Answer: The setting of premiums is something that has historically been a matter of state law and regulation, so that the dynamics of that state and its population and risk pool and consumer behavior can be taken into account. Nevertheless, of course, if confirmed as HHS Secretary, my role would be to implement the law as it is now written.

1332 Waivers

36. The ACA included a provision known as the State Innovation Waiver (SIW), or 1332, that provides states the opportunity to tailor their own health care system in a way that best aligns with the individual state's needs. This waiver was written to give states a chance to implement the ACA better; it was not written as a tool to undermine the law. States may apply to use these waivers beginning January 1, 2017.

    As a reminder, a waiver must meet the following requirements:

    - Ensure that individuals get insurance coverage that is at least as comprehensive as provided under the ACA.
    - Ensure that insurance coverage offered to individuals is at least as affordable as it would be under the ACA.
    - Ensure that as many people are covered as would be under the ACA.
    - Not increase the Federal deficit.

    Please respond to the following questions:

    a. **Question: What opportunities do you see for states to use the SIW? Are there particular reforms that you think would enhance access to affordable, quality coverage?**

    Answer: These waivers present an opportunity for CMS to encourage state innovation and allow for adaptation of national requirements to the needs of individual states. If confirmed, I would work with CMS to enable States to utilize this -- and other -- authority provided by Congress to ensure access to high-quality, affordable health insurance.

    b. **Question: How do you envision the SIW working in conjunction with Medicaid and any corresponding Medicaid waivers? What checks would you put in place to ensure that those individuals entitled to Medicaid receive the full benefits and protections afforded them under Title XIX?**

    Answer: There is a tremendous opportunity to allow states to innovate with respect to the intersection of their Medicaid programs and qualified health plans and the risk pools within each. State fair hearing processes (as well as the Medicaid waiver process and CMS oversight) provide substantial procedural and other protections that would address concerns regarding Medicaid beneficiaries not getting benefits due to them.

    c. **Question: What precautions would you put in place to ensure consumers are protected in states that choose to move forward with a 1332 waiver application?**

    Answer: The statute itself has protections in place relating to the findings that must be made that would protect consumers in states that move forward with a 1332 waiver application. Furthermore, the democratic process in each state, where government is even closer to the people, provides substantial protection with regards to any 1332 waiver

application and its implementation. Such protection may well be even more effective than that available to consumers vis-à-vis the federal government.

d. **Question: What steps would you take, as Secretary of HHS, to implement this provision, as intended by Congressional drafters, to ensure it is not used to undermine the ACA?**

Answer: As part of the ACA, the use of section 1332 to allow states to innovate would not undermine the ACA. In fact, failing to successfully use this important tool to allow states flexibility with regards to the ACA as allowed by the law would undermine the ACA.

Rural Health

37. Americans living in rural areas often have difficulty accessing quality care due to physical and economic barriers. The Health Resources and Services Administration estimates that 65 percent of primary care health professional shortage areas are in rural areas. These challenges translate into significant health disparities for rural populations, including higher rates of chronic disease and disability as well as lower life expectancy. Rural Americans have also historically experienced lower rates of insurance. The Affordable Care Act provided new access to coverage for people living in rural areas through the Health Insurance Marketplaces and Medicaid expansions, as well as critical consumer protections.

Question: If confirmed how will you protect access to quality health care in rural areas?

Answer: Too often rural health care is overlooked in the broader discussion of national health care issues. Significant health disparities exist for rural populations for a variety of reasons, including challenges with access to affordable coverage and health care services. Rural Americans are acutely aware of the dire need for expanded health insurance options. If confirmed, I will work tirelessly to address the health care needs of all Americans, rural or urban.

Pre-Existing Conditions and Continuous Coverage Requirement

38. The Affordable Care Act prohibits insurers from denying coverage to individuals with pre-existing conditions, charging them higher premiums, or refusing to cover benefits related to a pre-existing conditions.

Your Empowering Patients First Act (H.R. 2300 in the 114th Congress) repeals the Affordable Care Act in its entirety (including the protections for those with pre-existing conditions) and instead puts in place a "continuous coverage requirement," meaning that individuals with pre-existing conditions must maintain continuous health insurance coverage for at least 18 months in order to qualify for protections against discrimination by insurers. Under your legislation, insurers would once again be allowed to exclude coverage of a pre-

existing condition for lengthy periods of time or charge much higher premiums unless individuals had maintained continuous coverage for at least 18 months.

According to a recent report from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), up to 133 million non-elderly Americans may have a pre-existing condition, and nearly one-third (44 million) went uninsured for at least one month during the two-year period beginning in 2013.

If any of these individuals were to face difficult circumstances that resulted in a temporary loss of coverage — such as losing a job or being unable to work due to serious illness — your legislation would allow insurers to refuse to cover services related to the pre-existing condition or charge a much higher premium than many of these individuals would likely be able to afford.

Question: Do you agree that individuals with pre-existing conditions who experience a loss of coverage — for example, due to the loss of a job or being unable to work due to a serious illness — should not be denied coverage for their condition or charged high, unaffordable premiums as a result of that temporary loss of coverage?

Under the continuous coverage requirement included in your Empowering Patients First Act, what would prevent insurers from doing exactly that to any individual with a pre-existing condition who experiences a temporary loss of coverage?

Answer: I believe it is important that we as a nation make sure that every American has access to the kind of mental health care and health coverage that best meets their need. Additionally, it is imperative that all Americans have access to affordable coverage and that no one is priced out of the market due to a bad diagnosis. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

Human Services Programs

39. In recent years, there has been an increasing focus on using evidence to make policy decisions.

    a. **Question: What is your view on this?**

    Answer: There is no question we must use available evidence when making governmental decisions.

    b. **Question: What evidence would you use to decide whether policies or program changes that you have championed are successful?**

Answer: When championing policy or program changes, outcomes should always be a top indicator when determining whether or not those changes are successful.

c. **Question: What evidence leads you to believe that TANF was a success?**

Answer: Since the passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

40. The annual data from HHS through the Adoption and Foster Care Analysis Reporting Systems (AFCARS) released in fall 2016 show a third consecutive annual increase in foster care to 427,910 children. This represents an eight percent increase since 2012. Your home state is no exception. A recent AP story stated that, "the most dramatic increase has been in Georgia, where the foster-care population skyrocketed from about 7,600 in September 2013 to 13,266 last month. The state is struggling to provide enough foster homes for these children and keep caseloads at a manageable level for child-protection workers."[1] HHS recently indicated that:

> A *rise in parental substance use is likely a major factor driving up the number of children in foster homes. Citing opioid and methamphetamine use as the most debilitating and prevalent substances used, some state officials expressed concern that the problem of substance use is straining their child welfare agencies.*[2]

Clearly substance use is having a big impact on children, families and child welfare systems. I am particularly concerned about the strain the epidemic is placing on grandparents and other relatives who often unexpectedly take on the role of caretaker for children in foster care and at risk of entering foster care. Thankfully, there are programs that work and can even save taxpayer dollars over the long run. For example, research shows that when parents are able to get into substance use treatment programs that permit them to live with their children, two-thirds of these parents successfully complete the program. That compares with only one-fifth of parents when their children aren't allowed to stay in the treatment facility with them.[3] The results achieved by these model programs have saved millions of dollars every year in the costs of keeping kids in foster care.

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[1] http://www.bigstory.ap.org/article/12658e69b70148fc8d4743fa631fa9f9/5-states-struggle-surging-numbers-foster-children

[2] https://www.acf.hhs.gov/media/press/2016-number-of-children-in-foster-care-increases-for-the-third-consecutive-year

[3] https://www.ncbi.nlm.nih.gov/pubmed/11291901 and https://www.ncbi.nlm.nih.gov/pubmed/11291900

a. **Question: What will you do to ensure that drug treatment and services will be both maintained and coordinated to target these families that need treatment and whose children could end up in foster care without the appropriate services?**

Answer: There needs to be better coordination between federal departments, state governments, and local governments to ensure we are meeting the challenges of one of the great crises of our times: the opioid epidemic. A top agenda of all levels of government is to ensure innocent children, including those in foster homes, are protected from the scourge of this epidemic. As a strong proponent of the Comprehensive Addiction and Recovery Act of 2016, I will do all I can to effectively administer and implement this law should I be confirmed as Secretary.

b. **Question: How will you help grandparents and other family members receive the supportive services they need in the event that parents cannot safely retain custody of their children?**

Answer: Should I be confirmed as HHS Secretary, I will do all within my power, under the laws passed by Congress, to help grandparents and other family members receive supportive services.

c. **Question: Will you pledge to me that, if confirmed, you will work with me to provide federal support for effective programs, and to ensure that the children and grandparents caught up in the opioid epidemic get support from your Department?**

Answer: I absolutely pledge to work with you to ensure support for effective programs and to see that children and grandparents get appropriate support from HHS to deal with the tragic opioid epidemic.

41. As part of the Comprehensive Addiction and Recovery Act of 2016, Congress required states to have plans of "safe care" for infants born exposed to substances.[4] This requirement, along with numerous existing requirements, is a condition of state receipt of grants under the Child Abuse Prevention and Treatment Act, or CAPTA. Grants to states under CAPTA total $26 million per year. Discretionary spending for child welfare services under CAPTA, the Adoption/Kinship Incentives Program, the Promoting Safe and Stable Families Program and Child Welfare Services have all faced significant reductions in appropriations over the past five years.

a. **Question: What is your position on proposals that would move mandatory funding to discretionary funding (thus limiting the Committee's ability to fund both child welfare and other vital services)?**

[4] http://www.cwla.org/discussion-on-plans-of-safe-care/

Answer: This is a legislative matter. Should I be confirmed as HHS Secretary, I will implement the laws passed by Congress.

b. **Question: How will you ensure adequate funding for these services that have suffered significant reductions over the recent past despite a backdrop of increasing foster care numbers?**

Answer: Should I be confirmed as HHS Secretary, I will strive to make effective use of all dollars appropriated by Congress in order to provide the most effective services possible.

42. The United States is the only industrialized country without paid maternity leave.[5] The President has endorsed such leave for new mothers.

Question: If confirmed, how might you lead the Department to help support this goal? Please be specific about resources and expertise that may be available at HHS, including in such areas as benefit design, eligibility determination, IT systems, and program access.

Answer: If I am so honored as to be confirmed as HHS Secretary, I will implement the laws passed by Congress and support the President's initiatives as they fall within HHS' authorities. I will do so in a way that is as effective and as efficient as possible, drawing on the expertise and experience of the fine men and women currently working at HHS.

43. Access to high-quality child care is fundamental to the economic security of families and too many parents cite lack of dependable child care as a key barrier to finding and maintaining employment. The President's child care tax proposals would primarily benefit high-income families through tax deductions, while providing little or no help to low- and middle-income families.[6] The most significant federal child care program for families of modest means is the federal Child Care and Development Block Grant (CCDBG) which provides funds to states to help low-income families afford child care of their choice. Yet the CCDBG serves only one out of seven children eligible for assistance.

Question: If confirmed, under your leadership how might the Department improve access to high quality child care? Please be specific about resources and expertise that may be available at HHS, including in such areas as benefit design, eligibility determination, IT systems, and program access.

Answer: Should I be confirmed as HHS Secretary, I will implement the laws passed by Congress. I will do so in a way that is as effective and as efficient as possible, utilizing the

[5] http://www.oecd.org/els/family/PF2_5_Trends_in_leave_entitlements_around_childbirth.pdf
[6] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2842802&download=yes

ample and exemplary expertise available by the fine men and women currently working at HHS.

44. As Budget Chairman, you proposed eliminating funding for the Social Services Block Grant (SSBG), a flexible funding stream for social services programs such as substance use disorder treatment services, child protection, elder protection, services for the elderly like Meals on Wheels, and other critical safety net programs. It also helps fill in financial gaps for overburdened state foster care systems which are facing an increased strain in light of the opioid epidemic.

    a. **Question: In light of increased demands on state human services programs brought on by the opioid epidemic, has your position on the SSBG changed?**

    Answer: During my time in Congress, I have been acutely aware of the need to eliminate duplicative programs and strengthen those programs that work. However, as SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be so honored as to be confirmed as HHS Secretary.

    b. **Question: If not, where do you suggest states turn to make up for the loss of these flexible SSBG dollars if funding is eliminated? Please be specific in terms of which programs you believe would fill the void left by SSBG.**

    Answer: Given the nature of our federal system, there is not a one-size fits all approach to how states might react should there be an elimination of any federal program.

    c. **Question: Can you explain what makes the flexibility in the Social Services Block Grant inherently different and worse than either existing or proposed block grants (such as TANF as it exists or Medicaid as you have proposed)? I'd be especially interested in why you consider SSBG to be a failure while you consider TANF to be a success.**

    Answer: As a 2011 GAO report pointed out, SSBG is a program of fragmentation, overlap, and duplication. SSBG essentially offers a no-strings-attached approach whereas TANF, while maintaining a great deal of flexibility for the states, has been successful in moving recipients off of welfare and on to work. That being said, SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be confirmed as HHS Secretary.

45. One of the most significant sources of assistance on the human services side of the Department of Health and Human Services is Temporary Assistance for Needy Families, or TANF. During the hearing, in your response to Senator McCaskill, you touted the success of TANF. However, according to HHS data, between 1996 – when the welfare reform law was

enacted -- and 2015, the number of poor families in Georgia receiving support through TANF dropped from 82 per 100 to just 5 families per 100 while the population of poor Georgia families increased by over 50 percent.[7] While Georgia is one of the most drastic examples, this overall trend is not unique to your home state. Nationally, TANF reached 68 percent of poor families when the 1996 law passed. It now reaches just 23 percent of such families, despite the fact that extreme poverty has more than doubled.[8] Moreover, TANF has faced effective cuts of over 30 percent since its creation in 1996 and benefit levels have also declined.[9]

a. **Question: Do you believe TANF has been a success both across the nation and in your home state of Georgia?**

Answer: Yes. Since the passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

b. **Question: What metrics do you use in making this determination? Please specifically address time periods beyond 2005 in describing your views.**

Answer: I think the best way to measure the success of the law is to see where the nation was prior to its passage and where we are now. As I've pointed out, since passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

c. **Question: Can you provide a commitment that Medicaid will not see cuts like what you've proposed in your budget and what has happened to TANF?**

Answer: I will provide a commitment that if I am honored to be confirmed as HHS Secretary, I will faithfully implement and administer all the laws passed by Congress.

46. President George H.W. Bush's welfare advisor and one of the conservative architects of the 1996 law, Ron Haskins, has said, "States did not uphold their end of the bargain," and argued that TANF is not a model for other programs, asking "So why do something like this

[7] http://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ga.pdf and http://www.cbpp.org/research/family-income-support/how-states-use-funds-under-the-tanf-block-grant

[8] http://www.cbpp.org/research/family-income-support/tanf-continues-to-weaken-as-a-safety-net and http://poverty.ucdavis.edu/faq/what-deep-poverty

[9] http://www.cbpp.org/research/family-income-support/tanf-cash-benefits-have-fallen-by-more-than-20-percent-in-most-states and https://fas.org/sgp/crs/misc/RL32760.pdf

again?"[10] A recent piece published by the conservative think-tank, American Enterprise Institute came to a similar conclusion noting that unfortunately, "some states have abandoned their responsibility to provide support to poor families and help them get jobs," and that enough states have stopped spending money on core services that, "it tarnishes the entire program."[11]

However you resisted recent Republican-authored legislation that aimed to ensure states met even the most basic TANF spending obligations.[12] You insisted on changes that essentially would grandfather in practices that let Georgia and other states continue to, to use the AEI publication's words, "abandon their responsibility to provide support to poor families and help get them jobs."

a. **Question: If confirmed, will you continue to oppose efforts to ensure states hold up their end of the bargain with respect to investing their own dollars into the TANF program?**

   Answer: States should contribute their part in state-federal human services programs, even if we don't always agree on the method for getting there. I have an open mind and welcome proposals to improve state-federal human services programs to achieve the goal to reduce low-income families' dependence on government aid through high levels of paid work, especially those that are well supported by evidence. We have a duty to the American taxpayers, and the people these programs were created to help, to find workable solutions to problems within these programs. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President that reform state-federal human services programs.

b. **Question: Specifically, will you advise the President to oppose legislation, like HR 2959 as introduced in the 114th Congress, that would phase out the practice of states being able to count third party spending towards their TANF maintenance of effort requirements?[13]**

   Answer: The ultimate objective of human services programs is to help people stand on their own again after they have fallen down. Certain interpretations cut against this objective by keeping people down even when they want to stand up. I have a broad and open mind and welcome proposals to improve programs like TANF that would help people stand on their own again, especially those that are well-supported by evidence. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

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[10] http://www.cbpp.org/blog/tanfs-worsening-track-record-shows-why-its-not-a-model
[11] https://www.aei.org/publication/welfare-reform-progress-states-step-up/
[12] https://waysandmeans.house.gov/event/39841647/ and http://mlwiseman.com/wp-content/uploads/2016/05/Profiles-in-Courage.052216.pdf
[13] https://www.gpo.gov/fdsys/pkg/BILLS-114hr2959ih/pdf/BILLS-114hr2959ih.pdf

47. In your testimony and meetings with Committee staff, you stressed the need to establish better measures by which to evaluate the effectiveness of federal human services programs. As you know, timely, accurate and relevant evaluations rely on: modern, efficient and integrated state and federal data systems; effective data use agreements; and transparent and strong privacy and data security measures. Moreover, system modernization cannot only improve client services but reduce waste, fraud and abuse. However, much of the funding currently being used to modernize and integrate systems comes through ACA and the OMB A-87 waiver.

    Question: Will you commit to working, if confirmed, with Congress and the Administration to sustain the current efforts to improve state and federal health and human services data systems?

    Answer: Good data is an essential element for ensuring that we have accurate information and are able to effectively manage the programs under our charge. While funding decisions ultimately rest with Congress, if I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President to modernize state and federal human services data systems.

48. The Maternal, Infant, and Early Childhood Visitation program (MIECHV) is a program that members on both sides of the aisle have championed due to the demonstrated success of its models in improving the health and well-being mothers and children. MIECHV's innovative model has well-established goals, outcomes and metrics.

    MIECHV is due for reauthorization this year. At current funding levels ($400M/year), the Department of Health and Human Services (HHS) estimates that only 3% of the eligible population receives MIECHV services. To me, reauthorization represents an opportunity to increase access to the program and improve the life course of children born into low-income households, while also reducing preventable government spending in the short and long term.

    In your home state of Georgia, the Great Start Georgia program receives MIECHV funds. The program's aim is to provide evidence-based home visiting services to those families who are most in need of support and has met all 6 program benchmarks, including maternal and newborn health, family economic self-sufficiency, improving at-risk students' school readiness, and reducing crime and domestic violence.

    Question: If confirmed, how do you plan on continuing the successful MIECHV program?

    Answer: I share your goal of increasing access to affordable, quality health coverage. While I cannot comment specifically on legislation that would reauthorize MIECHV, I look forward to working with you on examining this program's funding and working on ways to improve rural and child health using evidence-based approaches.

Questions for the record from Senator Bill Nelson

1. Your health proposal would remove protections for individuals with pre-existing conditions, allowing insurers to charge them higher premiums or denying them coverage altogether, unless an individual has maintained coverage for 18 months. Your bill would expand high-risk pools as an option to individuals with pre-existing conditions. In Florida, more than 7.8 million people have pre-existing conditions.

   Question: Please explain how you believe high-risk pools will provide quality coverage to the 7.8 million people in my state who have pre-existing conditions.

   Answer: Pooling mechanisms that allow individuals to come together for the purchase of coverage, like the traditional Blue Cross Blue Shield Plan, have been successful in bringing down the cost of insurance for Americans. I believe this same concept could be successful in pooling the risk among those Americans with pre-existing conditions.

2. **Question: Have high-risk pools been successful in providing adequate and affordable coverage in populous, high-costs states like New York or Florida?**

   Answer: If confirmed, I look forward to working with you to implement commonsense solutions that prioritize flexibility for states like New York and Florida to design and operate their own high-risk pools or other risk-mitigation programs that suit their citizens' unique needs.

3. You introduced the 2015 reconciliation bill, which would have repealed key parts of the Affordable Care Act, had it not been vetoed. The nonpartisan Congressional Budget Office released a report on the effects of your bill, including increased numbers of uninsured Americans and increased premiums.

   Last week, President Trump said the Republican replacement plan is "coming down to the final strokes." He said that as soon as the HHS Secretary is confirmed, a repeal and replace plan will be submitted, "essentially simultaneously."

   Question: Is there a nearly fully formed replacement plan?

   If yes: What's in the replacement plan?
   Does it provide insurance coverage for everyone as President Trump said?

   a. **Does it protect individuals with pre-existing conditions from paying higher premiums or being denied coverage altogether?**

   b. **Does it allow children to stay on their parents' insurance until age 26?**

c. **Does it ensure that individuals struggling with substance use disorders or diagnosed with behavioral health conditions have adequate access to quality treatment?**

Answer: Plans for real health care reform are a work in progress, but the President and I share the same goal: to provide relief to all Americans from Obamacare. Obamacare has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship. The goal is to make certain that every single American has access to the coverage they want for themselves

4. **Question: What will you do to provide coverage to the more than 800,000 Floridians that could have been covered by Medicaid expansion?**

Answer: I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

5. **Question: Can you explain how, under a Medicaid block grant program, states like Florida would cover the unforeseen costs associated with public health crises, like Zika virus, or high cost prescription drugs, or unexpected sudden changes in demographics without harming another population?**

Answer: My work in the Congress has been focused on how to improve Medicaid and provide additional flexibility. If I have the privilege of being confirmed as Secretary, I would look forward to the opportunity to work with states and Congress using the tools and authorities given by Congress in legislation. The mechanics of any new Medicaid program along the lines described would be a legislative decision that would need to account for how to encourage states to save for such eventualities or how the federal and state governments do so together.

6. Florida is currently in the process of renegotiating its section 1115 Medicaid managed care waiver.

Question: What safeguards and beneficiary protections do you believe HHS should keep in place when reviewing Medicaid waivers?

Answer: 1115 waivers are an important tool for states to innovate within the Medicaid program, as they have for many years prior to the ACA becoming law. The statute itself has requirements for certain procedures. Furthermore, the democratic process in each state, where government is even closer to the people, provides substantial protection with regards to any 1115 waiver application and its implementation.

7. You introduced a bill to allow practitioners to enter into private contracts with their Medicare patients and charge higher fees than what is currently allowed under the Medicare program. Currently, when seniors in Medicare see their doctors, they are responsible for a set amount of costs and don't encounter any surprise bills. Under current law, physicians who choose to participate in Medicare are not allowed to bill their patients for any costs that remain once Medicare pays their share of the bill, a practice that is commonly known as balance billing.

   Question: Did you know that half of all Medicare beneficiaries had incomes of less than about $24,000 and savings below $63,350 in 2014? Is this the population that your bill targets?

   Answer: *The Medicare Patient Empowerment Act* is one approach to giving our seniors more flexibility within the Medicare Program and providing the opportunity to make decisions with their physicians without interference from Washington. The measure would help ensure that Medicare beneficiaries maintain adequate access to health care professionals by increasing the number of physicians who will accept Medicare patients and addressing physician shortages by attracting new professionals to the field of medicine. In addition, the bill provides safeguards to Medicare beneficiaries. More importantly, my legislation would allow a provider to see a Medicare patient pro-bono or charge minimal cost (below the standard fee schedule) without prosecution. Without this legislation, a physician can be charged with fraud for failure to attempt to collect the full coinsurance amount under Medicare.

8. The Medicare Advantage program provides quality care to over 1.6 million Floridians and over 18 million seniors across the United States.

   Question: Do you have any ideas about how to strengthen and build upon this vital and proven part of the Medicare program? In your role as Secretary of HHS, will you commit to supporting Medicare Advantage and protecting the nation's seniors as they age?

   Answer: Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. If confirmed as Secretary, I would seek to ensure Medicare Advantage remains a stable option for beneficiaries and that Medicare Advantage plans are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want.

9. Today, I joined a bipartisan group of Senators in reintroducing the Public Health Emergency Response and Accountability Act, which would fund the nearly empty Public Health Emergency Fund through mandatory appropriations designated as emergency spending, a proposal modeled after FEMA's disaster relief fund.

   Question: As HHS Secretary, would you work with me to protect my constituents from the Zika virus and other public health emergencies? Do you support the creation of an emergency health fund to provide mandatory appropriations to fight Zika and other

infectious diseases?

Answer: If confirmed as HHS Secretary, I give you my word I will do all within my power to protect your constituents, and the constituents of every Senator, from the Zika virus and other public health emergencies. Should Congress create a new program or alter an existing program I will work to ensure the program is as effective as it can be in fighting Zika and other infectious diseases.

10. The increased use of generic drugs results in real savings due to their lower costs as compared to brand name drugs. Senator Collins and I asked GAO to examine the factors behind recent spikes in some generic drugs. GAO found that Part D generic drug prices declined overall since 2010--they fell about 59 percent. Additionally, GAO found that 300 of the more than 1,400 established generic drugs analyzed had at least one price increase of 100 percent or more between 2010 and 2015.

    Question: What do you believe should be done to keep generic drugs affordable?

    Answer: I appreciate that generic drugs play an important role in meeting many American's health care needs. If confirmed, I look forward to focusing on how we can make health care more affordable, including prescription drugs, and build on policies that have helped to empower patients in meeting their health care needs.

11. Amyotrophic lateral sclerosis (ALS) usually strikes people between the ages of 40 and 70, and for unknown reasons, military veterans are approximately twice as likely to be diagnosed with ALS. There is currently one FDA approved drug that modestly slows the progression of ALS in some people. While there is no cure or treatment that that halts or reverses ALS, scientists have made significant progress in learning more about this disease.

    The Centers for Disease Control and Prevention operate a National ALS Registry, which is a critical resource for 1) providing data to researchers focused on developing treatments and prevention strategies; and 2) matching patients to potential clinical trials.

    Question: Please advise how the Administration will support this work in Fiscal Year 2018 and work with Congress to make the registry even more effective at confronting ALS.

    Answer: ALS is a devastating disease with far reaching consequences for both those afflicted and their families, and as a physician I understand the hardships these individuals must endure. If confirmed, I plan to work to advance patient-focused healthcare, which will support efforts to better serve those suffering from ALS.

12. The ACA reauthorized the Minority Centers of Excellence (COE) program, housed within the Department of Health and Human Services. The Florida Agricultural and Mechanical

University (FAMU) Pharmacy, located in Florida, is a grantee. COE supports curriculum-based initiatives for increasing minority and underrepresented individuals to become health professionals.

Question: Do you support preserving important programs like COE, Health Careers Opportunities Program, and Area Health Education Centers?

Answer: As a physician, I understand the critical importance of diversity among healthcare practitioners in order to meet the varied health care needs of the American people. If confirmed, I look forward to working with you and others to ensure that we are supporting efforts to increase diversity within our nation's health care workforce as part of advancing patient-focused health care.

13. CT colonography (CTC), also known as virtual colonoscopy, are diagnostic medical tests, which produce detailed images of the colon by using a combination of 2-dimentional x-rays and a 3-dimentional computer views. They have the ability to identify lesions and tumors on the kidneys and other organs and blockages in the coronary arteries.

    Currently, Tricare and private payers in 21 states and the District of Columbia cover virtual colonoscopies for colorectal cancer screening, but Medicare does not.

    Question: Will you use your authority as Secretary to consider the addition of virtual colonoscopies as a colon cancer screening option for Medicare beneficiaries?

    Answer: As you know, CMS has a detailed process for making determinations regarding whether items and services are reasonable and necessary, if they can be considered eligible for Medicare coverage given other restrictions and prohibitions. I understand CMS' decision to cover CT colonography only for diagnostic testing but not screening was based on the state of the technology at the time and the possible need for a confirmation colonoscopy in so many cases. If confirmed as Secretary, I would look forward to working with you to understand if revisiting this issue is appropriate and warranted.

14. On July 16, 2015, Proposed/Draft Local Coverage Determination for Lower Limb Prostheses (DL33787) (Draft LCD) was published by the four Durable Medical Equipment Medicare Administrators ("DME MACS"). Last year, the Coverage and Analysis Group, headed by CMS, was created to review the DME MAC recommendations. That Group continues to deliberate.

    Question: Can you speak to what actions as an Administrator you would take on finalizing this Draft LCD?

    Answer: Medicare coverage for prostheses can be a particularly challenging topic given the role this durable medical equipment plays in the lives of many Medicare beneficiaries. I understand CMS has stated it is committed to providing high quality care to Medicare

beneficiaries in need of a prosthesis, that it has committed to a Workgroup the task of making recommendations concerning the best and most relevant measures in this realm, and that CMS will ensure there is opportunity for public comment and engagement. If confirmed as Secretary, I would be pleased to work with you to look into the timing of this matter and see what can be done to either expedite it or further support the work so there is assurance of its comprehensiveness and objectivity.

15. Representative Price, I know you are very familiar with the Centers for Medicare and Medicaid Service's (CMS) Home Health pilot program known as the "Pre-Claim Review Demonstration (PCRD)" which affects five states, including Florida. I am concerned that the PCRD may restrict beneficiary access to timely services, divert clinical resources to paperwork management, and incur high administrative costs. These concerns were amplified after hearing what the State of Illinois had been dealing with when PCRD began there in August 2016.

    In response to my concerns, CMS delayed PCRD in Florida until April 2017. While I understand the concern, CMS has with needing to tackle the improper payment rates, PCRD may not get to the root of the problem.

    Question: As Secretary, how do you plan to tackle the problem of improper payments? Do I have your commitment that you will work with me to alleviate the concerns raised by the PCRD?

    Answer: The topic of improper payments is one of concern in the Medicare program – both overpayments and in some cases underpayments. Tackling them requires close support for the payment integrity team within CMS and close cooperation with the Office of the Inspector General and the Department of Justice. But it also involves a definition of scope and a prioritization – which improper payments are ones that reflect services not rendered and which involve a missing signature on a form. With that prioritization in mind, I am hopeful we can align resources to those areas of highest risk.

    As to the Pre-Claim Review Demonstration (PCRD), if confirmed, I would be pleased to work with you to address your concerns. For example, we may want to explore the experience of the Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport demonstration to understand if there are applicable lessons for PCRD or vice-verse.

16. During the public comment period for the FDA's tobacco deeming rule, the Small Business Administration's Office of Advocacy filed concerns that the economic impact analysis conducted by FDA was "deficient" and should be recalculated. Small business premium cigar retailers and manufacturers in my state have expressed the same concern to me. Unfortunately, FDA took no action to address these concerns.

Question: Do you believe additional review of the costs of this regulation should be conducted before any additional implementation?

Answer: Whenever the federal government implements its regulatory responsibilities, it is important to consider the costs, especially those imposed on small businesses. Any time economic impact analyses are conducted, I believe they must be fact-based. If I am confirmed, I would seek to better understand the SBA's views of the regulation in question, which is consistent with the President's commitment to reduce the overall regulatory burden on American businesses.

Questions for the record from Senator Tom Carper

1. The number one concern I hear from my constituents about health care is affordability. I was pleased to hear the president say that under his plan, health insurance will be better and less expensive for all Americans. Americans cannot afford to pay more for their health care. Even supporters of the president value the health benefits they have gained through the Affordable Care Act and could not bear the higher deductibles and decreased benefits that your earlier plans have called for.

   Question: Can you ensure that under the president's health care plans, health insurance premiums, deductibles, and co-pays will decrease for all Americans? How exactly will you do this?

   Answer: President Trump and I have the same goals for health care reform and the same general approach to meeting those goals. Neither one of us is wedded to a particular plan to the exclusion of all others. We see eye-to-eye on this, and are looking forward to giving the American people what they've been longing for, for seven long years: real healthcare reform. But they have never wanted Obamacare: It has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship.

2. The Congressional Budget Office (CBO) has found that repealing the ACA will cause more than 30 million Americans to lose their insurance and increase premiums by more than 20 percent.

   Question: Do you agree that the president's executive order to begin repealing the Affordable Care Act while there is no alternative plan creates instability and uncertainty that will only drive up costs in our health care system?

   Answer: The insurers are deciding right now as they come forward in March and April what the premium levels will be for 2018. What they need to hear from us is a level of support and stability in the market, the kinds of things that are able to provide stability. There are counties in the state where there is only on provider. We must, as policymakers, ask what is going on. Where are the problems out there? The President's Executive Order is directed towards exactly that -- reducing costs and the other burdens on the American people imposed by Obamacare. The initial reactions to the Order from plans and others indicate this is something they anticipated based on the President's promises and that the recent and current discussions regarding how to address the issue of costs have been productive. In fact, it is the costs of inaction which are not acceptable.

3. **Question: Do you believe that all Americans, regardless of income, should have health insurance and does the president share your views on this? Have you told the president that repealing the ACA without a replacement means 32 million Americans will lose their health insurance and add $9 trillion to our national debt? Have you had direct discussions with members of the Transition Team or the president's current healthcare advisers since your nomination? Would you insist that Congress hold multiple**

bipartisan hearings on the president's health care proposal? Will you commit to, should you be confirmed, to answer our questions when such a proposal is sent to Congress and evaluated by the non-partisan, independent Congressional Budget Office?

Answer: I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

4. 60 percent of the children born outside of marriage are from unplanned pregnancies. This is a major public health challenge, as children born from unintended pregnancies and raised in single parent households have a higher rate of mental health problems, a lower rate of high school graduation, earn less income than their peers, and cost more to taxpayers. Because of the Affordable Care Act, millions of American women can now afford contraception, without co-pay or cost-sharing, and the rate of unplanned pregnancies has dropped.

   Question: Will the president's plan to replace the ACA ensure these women will not have to pay more for contraception and put birth control out of reach for millions of young women and families?

   Answer: Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price.

5. Health care experts have found that obesity, smoking, and mental health challenges are the "root causes" of our country's most persistent public health challenges. Together, tobacco, obesity, and mental health lead to more than a million deaths and cost us more than half a trillion dollars each year. It's critical that all health insurance plans fully cover the treatment for these conditions. If the ACA is repealed, Americans would lose access to treatment for mental health care, smoking cessation, and obesity treatment.

   Question: Under the bills and proposals you have championed, would the treatment and cost of insurance coverage for obesity, smoking cessation, and mental health care remain the same or decrease?

   Answer: It has been the goal, for any legislation I have championed, for the treatment and cost of insurance coverage for all Americans to decrease.

6. The obesity epidemic has had a devastating impact on our health care system, increasing the prevalence of nearly every major chronic condition, including heart disease, hypertension, diabetes, and cancer, and costing our country hundreds of billions of dollars every year to treat the variety of conditions attributable to this increasingly prevalent disease. A critical

step in combating obesity was the decision by the AMA in 2013 to designate obesity as a disease. This designation is an important step towards ensuring the best medical care is provided to those suffering from this disease.

Question: Will you, as Secretary of Health and Human Services, follow the leading medical association and declare obesity as a disease and will you assist us in maximizing the use of all the medical interventions currently available to combat this crisis?

Answer: Obesity is a chronic condition that takes its toll over many years and in many quiet ways. I agree it is an important priority for all involved in the health care system to address this toll. This is particularly the case because obesity is generally a preventable condition and can be controlled through changes in behavior. Fundamental to that is the relationship between patient and doctor which our current system has undermined in many ways. I can tell you that I will consider the legal framework within which any decision regarding the formal designation of any disease ought to take place and come to any decision with these considerations in mind.

7. **Question: Have you ever been a member of the Association of American Physicians and Surgeons?** This group has said that the government poses a greater threat to patients than tobacco use, drug addiction, and excessive alcohol intake, and that patients should seek doctors who do not participate with Medicare, Medicaid, and private health insurers. **When you were a member of this group, did you agree with this position? Do you agree with this position now?** This group has also compared the use of advance directives – the process by which patients and their health care providers plan for end of life care decisions in advance and when they are of sound mind and body – as "population control". **Do you agree with this comparison?**

   Answer: My work has been focused on making sure that physicians and patients are ones making medical decisions, rather than the government. Once that relationship is undermined and patients do not trust their doctors or doctors do not think first about their patients then no other medical or public health goal can be achieved. This is important when it comes to chronic disease, preventive care and healthy choices, and life and death decision-making. For all these reasons, I have fought alongside many to ensure patients have these choices to make for themselves and with their doctors**.**

8. As you know, the Affordable Care Act prohibits health insurance companies from limiting coverage to individuals on the basis of sexual orientation and gender identity. But a number of your previous statements regarding lesbian, gay, bisexual, and transgender people indicate that you don't support these consumer protections.

   Question: As HHS Secretary would you support reversing these protections and jeopardizing the LGBT population's access to health care? As Secretary of Health and Human Services, would you uphold the department's efforts to ensure that health insurance companies do not deny or limit health care coverage to LGBT people?

Answer: If confirmed, my efforts and work as Secretary will be to seek the availability of the highest quality care for all Americans. The goal is to make certain that every single American has access to the coverage they want for themselves. Of course, consumer protections at federal and state levels ought to be available to all consumers, not just certain ones who meet certain criteria.

9. Data has shown repeatedly that federal resources devoted to fighting health care fraud is well worth the investment. The Health and Human Services Department has found that for every dollar that is invested to fight fraud, the government recovers $5. On January 23, 2017, the President announced a hiring freeze on government workers, which would include a freeze on hiring investigators and attorneys devoted to protecting Medicare and Medicaid from criminals. The GAO has repeatedly listed Medicare and Medicaid as two of the federal government programs most vulnerable to fraud, waste, and improper payments. Unfortunately, this freeze only leaves Medicare and Medicaid more vulnerable to fraud.

   Question: Do you agree with these concerns and if confirmed, will you recommend to the president that the hiring freeze should be lifted for federal workers fighting criminal activity, waste, and fraud in Medicare and Medicaid?

   Answer: The President's memorandum is not for time immemorial. It provides that within 90 days of its issuance, the Director of OMB, in consultation with the Director of OPM, shall recommend a long-term plan to reduce the size of the Federal Government's workforce through attrition and that the "freeze" will expire upon implementation of the OMB plan. If confirmed as Secretary, I will take into account in weighing in with OMB and OPM the clearly important role our fraud fighters play which you outline.

10. During your time in Congress, you have supported proposals that would block grant Medicaid or put a per capita cap on Medicaid spending. The Congressional Budget Office has found that reversing the Medicaid expansion under the Affordable Care Act would lead to the loss of health care for millions of Americans and would lead to state funding shortfalls of $1 to $2 trillion.

    Question: Do you support proposals to block grant or cap Medicaid? Do you agree that block granting or capping Medicaid would save the federal government as much as $1 to $2 trillion?

    Answer: Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with states to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. Of course, the specifics of any particular proposal to provide more flexibility to states will determine its budgetary consequence.

11. The American Association of Actuaries has pointed to risk corridors and other risk mitigation programs as important mechanisms for stabilizing our insurance markets. These programs

were also included in the Medicare Part D program and remain in place today. Please just give us a yes or no answer to the following questions.

Question: Do you support the use of these programs in Medicare Part D? Did you support these programs as a part of the state insurance marketplaces created by the Affordable Care Act? Do you think these types of programs should be included in any plan to improve on the ACA or to replace the ACA?

Answer: Risk adjustment is used to adjust payments to health plans based on the relative risk of plan participants. Reinsurance has been used to reimburse insurers for the cost of individuals who have unusually high claims. And risk corridors are used to mitigate the pricing risk that insurers face when they lack data on health spending for potential enrollees. Part D has successfully deployed these mechanisms consistent with the underlying direction of Congress. The issue with any of these programs is often in the way they are implemented and the direction Congress gives with respect to them. In any current or future legislation, it would be important to consider these issues closely.

12. You have expressed concerns with delivery system reforms and in particular, bundled payments.

Question: Please talk about your recommendations for how we can move away from fee for service reimbursement to a health care payment system that rewards better health outcomes and reduced costs.

Answer: For certain populations, bundled payments make a lot of sense. And they can often lead to both better health outcomes and reduced costs. But it is important we not get fixated on one of those two outcomes. That is, I support making certain that we deliver care in a cost-effective manner but we absolutely must not do things that harm the quality of care being provided to patients. What we ought to do is allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve healthcare delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, we ought to remember we are not talking about science experiments in a lab or a computer simulation, but about experiments involving real patients' lives.

13. **Question: During your time in Congress, how have you worked to strengthen and improve community health centers in your district and in the country? Do you think we should increase the presence of community health centers to increase Americans' access to health care?**

Answer: Community health centers are a vital part of our medical infrastructure. They fill a void in so many states and are often times the entry point if not the main source of health care. I have sought to support them to make sure they can provide the highest quality care and will continue to do so if confirmed.

14. I have always felt that we can't manage what we can't measure. You point to having good metrics as an important tool for ensuring we've made good progress. I agree with you wholeheartedly.

    Question: With your wealth of experience as a physician, a state legislator, a congressman, and the chairman of a major House committee writing major legislation, please share with me the metrics we should use to measure our progress towards a more just and equal health care system that ensures affordable and high quality health care for all Americans. If you cannot name any specific metrics, can you outline the process by which we should determine what metrics we should use to measure progress towards increasing access to health care?

    Answer: The fundamental metric for knowing that our system is on the right track is the centrality of the patient in the system and their ability to make choices about their care in consultation with their doctor. Without that, the most impressive facilities and technology are not serving our people's needs, nor is the most efficient system doing what is most important. With the patient at the center of the system as a foundation, all else is possible and achievable.

15. During the debate over the Affordable Care Act, Congress held more than 100 bipartisan hearings, roundtable discussions, and negotiations, which were predominantly open and transparent to the public. The legislation was open to amendment by both parties in lengthy committee markups and by the full Senate, completely evaluated by the Congressional Budget Office, and reported on extensively by the news media before Congress voted on final passage. I understand that you place a high premium on transparency and honesty.

    Question: Will you commit to having the same level of bipartisan discussion, transparency, and honesty in putting together the president's proposal for reforming our country's health care system and ensuring that all Americans will have affordable and high quality health care?

    Answer: The President has made clear his hope and plan for a replacement to Obamacare. At the same time, many in Congress have their own ideas. And the conversation about how those will play out is ongoing. That is the nature of our democracy. I certainly hope we will have bipartisan support for any approach to fixing the current system, which we must all agree is broken. If confirmed, I look forward to working with anyone in Congress willing to work with me and the Administration generally to come up with the best replacement plan under the procedures and involving the processes the Congress considers appropriate so as to make available the highest quality care to all Americans.

16. **Question: Do you agree with the president that the sale of health insurance over state lines will increase competition and lower the cost of health insurance? Section 1333 of the Affordable Care Act already allows states to form interstate compacts to allow for**

the sale of health insurance over states lines? The states of Georgia, Maine, Kentucky, and Wyoming allow for out-of-state insurance sales, but virtually no out of state insurers have tried to sell insurance in these states. **How would you increase the sale of insurance over state lines while maintaining consumer protections such as insurance coverage for contraception, preventive screenings, maternity care, and mental health treatment?**

Answer: The idea of allowing interstate sale of insurance may take many different forms. I agree with the President that it is an important option to increase competition and lower the cost of insurance. While the details of any such proposal would have to consider the extent to which benefit design varies among states, it is important that individuals be able to purchase the coverage that they want and there has to be a floor of creditable coverage.

Questions for the record from Senator Charles Grassley

1. **Question: As someone who is being considered to lead the Department of Health and Human Services, and as a physician, do you have any doubts about safety and effectiveness of vaccines?**

   Answer: I understand the significant impact vaccines have had on our Nation's public health, as well as the importance of patients having confidence in the therapies they receive as part of their care.

2. **Question: As a physician would you recommend that families follow the recommended vaccine schedule that has been established by experts and is constantly reviewed?**

   Answer: As a physician, I encourage individuals and families to consult with their physician on the most appropriate care for them and their loved ones.

Questions for the record from Senator Robert Menendez

Clampdown on Communications with the Public and Congress

1. Shortly after your hearing concluded, press reports came out that a memo was issued to employees of the Department of Health and Human Services and the National Institutes of Health prohibiting any external communication throughout the entire Department. Specifically, the press accounts quote the memo as stating "[f]or your additional awareness, please note that [HHS employees] have been directed not to send any correspondence to public officials (to include Members of Congress and state and local officials) between now and February 3, unless specifically authorized by the Department[.]"

   I find this to be an unconscionable clampdown of information and a rejection of basic transparency and accountability standards that should seriously concern all Americans. This is made all the more concerning given the health care, public safety, research and biodefense programs that operate within HHS.

   a. **Question: Do you support this directive or any other department-wide order to suppress the flow of information between the Department of Health and Human Services, the public and Congress?**

      If confirmed, do you commit to never imposing such restrictions on any agency, office, or employee at HHS that limits their ability to communicate with the public and Congress?

      During your hearing today you agreed "to provide a prompt response in writing to any questions that may be submitted to you or addressed to you by any senator of this committee[.]" Does you believe this directive prohibits you from fulfilling that commitment to the Committee?

      Were you aware this directive was going to be issued prior to the time of your hearing on January 24, 2017?

      Answer: The Acting Secretary Memo to Department of Health and Human Services operating and staff division heads is straightforward and consistent with Chief of Staff Memo issued on behalf of President Trump with regard to regulatory review of new or pending regulations and guidance. As noted in the HHS memo, the purpose of the directive is to ensure "President Trump's appointees and designees have the opportunity to review and approve any new or pending regulations or guidance documents." Furthermore, the Chief of Staff memo provides explicit exceptions for "emergency situations or other urgent circumstances relating to health, safety, financial, or national security matter..." This request is standard for a new Administration. With regard to correspondence to public officials, such as Members of Congress, the memo outlines a clear and expedited process for adequate review and is by no means intended to impede the agencies or staff divisions from continuing their important work on behalf of the American people, including routine constituent service communications.

Fidelity to Science and to Debunking Dangerous Falsehoods

2. During the hearing I raised a series of debunked and fake health and science claims, all of which have been perpetrated and advanced by the Association of American Physicians and Surgeons, a group to which you currently, or previously, have been a member. These debunked and factually inaccurate claims include linking undocumented immigrants to a spike in leprosy, connecting abortions to breast cancer, and claiming that the HIV virus doesn't lead to AIDS. This group has also promoted widely debunked and untrue claims that vaccinations lead to the development of autism spectrum disorder. These are dangerous claims made all the more toxic for being promoted by a group comprised of medical professionals. What's even more dangerous is that the President himself has a long history of promoting falsehoods linking vaccinations to autism.

a. **Question: Will you state unequivocally that vaccines do not have any link to the development of an autism spectrum disorder and confirm that such all claims are fraudulent and have been widely debunked?**

Answer: General scientific consensus at this time is that vaccines do not lead to autism spectrum disorder. As always, this is an area where patients and the parents of patients should consult with their doctor.

b. **Question: Will you, if confirmed to be the nation's highest ranking health care official, actively work to debunk these types of false health care and scientific claims?**

Answer: If confirmed, I will work to hold HHS to the highest scientific standards**.**

c. **Question: Do you ensure that no political appointee within any agency, department or office in the Department of Health and Human Services believes in, or has promoted, demonstrably false statements about health care practices or debunked scientific claims?**

Answer: As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. When confirmed, I commit to conducting the due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people.

d. **Question: Will you advise that the President not appoint anyone to the staff of the Executive Office of the President who believes in, or has promoted, demonstrably false statements about health care practices or debunked scientific claims?**

Answer: As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. When confirmed, I commit to conducting the

due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people.

Autism Policy

3. Since I first learned that New Jersey has the highest incidence of autism in the country I have been Congress's leading advocate for advancing federal policy to help individuals and families with autism and other developmental disabilities. Recently, the CDC released updated numbers showing that 1 in just 41 children in New Jersey are diagnosed with an autism spectrum disorder by the age of 8. This is the highest rate in the nation.

   In 2014, I authored the Autism Collaboration, Accountability, Research, Education, and Support Act of 2014, known as Autism CARES. Among the several key policies included in this law was the continuation of the Interagency Autism Coordinating Committee and the elevation of a senior Health and Human Service official to serve as the HHS Autism Coordinator.

   a. **Question: Do you commit to ensuring individuals appointed to these key positions maintain a fidelity to science, and will you ensure that they will have the ability and freedom to debunk false claims linking autism to vaccines (or any other similar demonstrable falsehoods) without fear of retribution from you or the White House?**

      Do you commit to promoting, through your capacity as Secretary and through the President's annual budget, increased funding for autism research and supports and services programs?

      What specific steps will you take as Secretary to promote and support a robust environment throughout the Department that focuses on research into diagnosis, treatments, supports and services, specifically those targeting adolescents and adults with autism and other developmental disabilities?

      The Centers for Disease Control and Prevention report that a child with an autism spectrum disorder can be diagnosed as early as age 2, yet children are frequently much older at the time of diagnosis. List the specific steps will you take to promote early diagnosis and early intervention?

      Answer: As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. If confirmed, I commit to conducting the due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people. HHS is involved in a number of autism-related initiatives with the important goal of helping the individuals and families living with autism. When confirmed, I look forward to continuing this important work on behalf of these individuals and families.

4. The Affordable Care Act, as part of the Essential Health Benefit Package for plans sold on the Marketplace, requires that all carriers provide coverage for behavioral health care services, including those for autism. This was an amendment that I had included into the ACA, and it has provided families across the nation with assurances that their children's coverage will provide them with the care they need.

    a. **Question: Do you commit to maintaining nationwide access to behavioral health care by preserving the Essential Health Benefits package?**

    Answer: My hope is to move in a direction where insurers offer products people want and give them the coverage they want. And in so doing, we want to not lose sight of our shared objective of the best and highest quality care being available to every American. I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

    b. **Question: Do you strongly disavow any attempt to weaken this coverage standard or any attempt at the Federal level to preempt states, like New Jersey, that have a long-standing state requirement that insurance provides benefits that cover services for autism?**

    Answer: I am respectful of the role of states and, if confirmed as Secretary, will work to provide states with flexibility along the lines described and consistent with President Trump's Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.

5. Medicaid is a literal lifeline to those with autism and other developmental disabilities. Every year, 50,000 of these individuals age out of school-based services and need access to home and community-based care to ensure they live as active and integrated a life as possible. This is largely accomplished through Medicaid.

    a. **Question: List the specific policies will you promote as Secretary to expand access to home and community-based services for individuals with autism and other developmental disabilities?**

    Answer: Every state is unique in their specific approach to the provision of services for the population eligible to receive HCBS, and we stand ready to assist states as they develop strategies to meet their particular goals.

    b. **Question: List the specific steps will you take to improve outcomes for transition-aged youth and ensure that they maintain access to services and supports?**

Answer: If confirmed, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue approaches that fit the needs of their States.

6. The Autism CARES Act of 2014 requires the Secretary of Health and Human Services to submit to this committee a report concerning young adults with autism and the challenges related to the transition from existing school-based services to those services available during adulthood. This report is long overdue.

   Question: When will this report be finalized? Will you prioritize the finalization and submission of this report to Congress before March 31, 2017?

   Answer: If confirmed, I would be pleased to work with you on the status and finalization of this report.

Community Health Centers

7. Federally Qualified Health Centers (FQHCs) are the health care home for more than 25 million patients nationwide with 494,912 Community Health Center patients in New Jersey. In New Jersey, FQHCs save the State and hospitals millions of dollars when patients are seen at health centers rather than in emergency rooms. FQHCs cost of care is substantially lower than other types of providers, even though they provide a wide range of ancillary services not offered in other health care settings. As an example, FQHCs in New Jersey have a lower average per-episode cost than health centers national, and almost half that of hospitals.

   Further, community health centers are essentially one-stop shops for health care, providing medical, oral health, mental health, substance abuse, and other critical services at the same location. The 23 New Jersey Community Health Centers make up the largest primary care network in the state, providing care to almost half a million patients in over 131 sites of care including in schools, homeless centers, and public housing. Beyond just providing health care, our state's FQHCs employ more than 180,000 individuals, and generate over $26 billion annually in economic impact to some of the nation's most distressed communities.

   a. **Question: What is the specific dollar amount that Community Health Centers stand to lose as a as a result of ACA repeal and the repeal of Medicaid expansion funding?**

      Answer: I am not aware of the specific dollar amount.

   b. **Question: How many fewer patients will not get health care services at Community Health Centers as a result of ACA repeal and the repeal of Medicaid expansion funding?**

Answer: I do not have this figure.

c. **Question: What will be the impact on any ongoing Community Health Center expansion project that will be halted as a result of ACA repeal and the repeal of Medicaid expansion funding?**

Answer: We are committed to supporting Community Health Centers, providing increased access to care for patients across the nation.

d. **Question: Please provide an economic impact, including lost jobs and diminished economic impact, that will occur as a result of ACA repeal and the repeal of Medicaid expansion funding?**

Answer: To my knowledge, repeal of the ACA is projected to have a positive impact on the labor market and the economy.

e. **Question: If the ACA is repealed, list the specific steps will you take to further promote the importance of seeking preventative care rather policies which encourage patients to wait until they have to go to the emergency room?**

Answer: Our goal is to ensure that all Americans have access to affordable coverage that best meets the needs of them and their families so that they can receive preventative care from the doctor of their choice in a primary care setting.

f. **Question: Do you commit to maintaining current funding levels for Community Health Centers, not only in the Department's annual budget submission to Congress, but in ongoing operations that will be financially damaged by the repeal of the Affordable Care Act?**

Answer: I support Community Health Centers, however, funding levels are determined by Congress. If confirmed, I will uphold the law as passed by Congress and signed by the President.

Interstate Sale of Health Insurance

8. One of the policies that you and President Trump often refer to in your talks about an ACA "replace" plan is to allow insurance to be sold across state lines. As you must be aware, the ACA already allows for this, and several states – including your home state of Georgia – have passed state laws to allow for it, too.

a. **Question: In the five years since Georgia started allowing out-of-state insurance to be sold, how many insurance companies have started selling out-of-state plans?**

b. **How has allowing out-of-state plans impacted consumer choice in available health insurance plans, what has been the impact on insurance costs, and what has been the impact on access to care in Georgia?**

c. **How many states have indicated they want to form a compact to allow out-of-state plans, under the current law?**

d. **How would this lack of interest on the part of states and insurance companies change under the plan you've previously proposed (e.g. Title III of H.R. 3200, the Empowering Patients Act)?**

e. **As a former physician who had to negotiate with insurance companies to be in their networks, wouldn't you prefer to work with an insurance company that knew you and your patients, or would you prefer one from across the country that knows nothing about you, your practice, or your patient population?**

Answer: It's no surprise that an overwhelming majority (85%) of Americans support the ability to purchase insurance across state lines. More important than insurance companies' views about more competition or state regulators' views about greater regulatory competition is the fact that American families are desperate for more affordable health care choices. It's our job to make certain that every American has access to the highest quality care and coverage that is possible. Opening up more health options for American families by allowing them to purchase a plan from another state will do just that. Understandably, insurance companies and states have been reluctant to take bold action to sell products across state lines with the heavy burden of Obamacare already on the books. Removing Obamacare's insurance mandates and regulations combined with the ability to reach more customers will ultimately reward American families with more choices at lower costs.

9. One of the consistent arguments you've made against the ACA is that it was a federal takeover of health care and that oversight of the health industry is better left to states.

Question: If you do in fact believe that, how does undermining states and their insurance commissioners by imposing interstate sale of health insurance follow that same logic?

Answer: If confirmed, I look forward to working with states to increase access to affordable coverage.

Recusal from AMA-Related Activities

10. The American Medical Association's (AMAs) House of Delegates is, to quote their website, the "principal policy-making body of the AMA." You've been a Delegate for more than a decade and have presumably been involved in the development of the organization's policies relating to key issues before both Congress and HHS during that time. You've stated that if

confirmed you intend to recuse yourself from any issues the AMA has worked on for one year.

a. **Question: How did you determine that a year is a sufficient period of time for your recusal from all AMA-related activity?**

   Answer: This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly-available ethics agreement.

b. **Question: Does the clock on this year start on the day you assume the role of Secretary or do you currently consider that year to have already started?**

   Answer: The terms of my publicly-available ethics agreement, which I entered into in consultation with the Office of Government Ethics and my designated agency ethics official, make clear that the one-year recusal window begins on the day of the confirmation.

c. **Question: If the Department's General Counsel, Office of Inspector General or any other authority within the HHS determines that a year recusal is insufficient to properly distance yourself from your previous work with the AMA, will you commit to extending the recusal period for the remainder of your tenure as Secretary?**

   Answer: I will abide by the obligations agreed to in my publicly-available ethics agreement, which I entered into in consultation with the OGE and my designated agency ethics official.

11. A quick search on the AMA's website shows that the organization has formally commented on issues as varied as Medicare Advantage, the physician fee schedule, FDA oversight of laboratory developed tests, Medicaid and CHIP, CMS quality measures, Medicare prescription drug benefits, electronic health record meaningful use requirements, guidelines for opioid prescribing, and the comprehensive joint replacement model you've spoken out against so frequently. Obviously the group representing doctors has myriad interests in the workings of virtually every agency and office within HHS.

    Question: Please provide me with documentation outlining exactly how will recuse yourself from all AMA-related activities, which includes specific details on the HHS policies this recusal impacts. Further, please provide a list of all personnel within the Department that will be designated to act on your behalf for all the listed polices for which you will be recused.

Answer: This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in his publicly-available ethics agreement.

I have not yet been confirmed or hired any personnel to assist efforts in the Department of Health and Human Services.

12. As a member of the AMA's House of Delegates for more than a decade, it's safe to presume that you are familiar with, and supportive of, their policies. One of these policies states that the "AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health" because they are the leading cause of premature death in the country.

Question: Do you agree that guns are a top cause of intentional and unintentional death, as the AMA states?

As a member of the AMA's House of Delegates, at any point did you fight against the AMA taking a stance declaring guns to be a public health issue?

Do you oppose government prohibitions on studying how gun violence affects the public health? If confirmed, will you commit to not imposing government prohibitions on any agency, department or office from conducting gun-related health research to improve public health?

Answer: Violence is a challenge in our society that deserves greater attention. All Americans want our communities to be safe places to live, learn, work and play. To my best recollection, I have not taken an individual stance on this matter. To the question of how best to prevent the tragic loss of innocent lives, I believe we must take a hard look at the underlying issues contributing to these tragic events, including too often unmet mental health needs among our citizens. A proper diagnosis and treatment as part of patient-focused care are critical to ensuring we are identifying indicators of violent behavior that may contribute to tragic events.

Evidence-Based Home Visiting Programs

13. I have been a strong supporter of the Maternal, Infant, and Early Childhood Visitation program (MIECHV), which has always enjoyed bi-partisan support. MIECHV was enacted as part of the Affordable Care Act to help states build capacity to provide in-home visits to at-risk mothers and families with the stated goals of improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting, and promoting child development and school readiness.

The Medicare Access and CHIP Reauthorization Act (MACRA), passed in 2015, the reauthorized the program for two years. This reauthorization maintains current funding, which unfortunately is only enough resources to provide services to only 3 percent of the eligible population is currently receiving MIECHV services. This points to a missed

opportunity to improve the life course development of children born into low-income households, while also reducing preventable government spending in the short and long term.

Question: Do you commit to supporting continuation of funding for the MIECHV program in the Department's annual budget submission?
Do you recognize the value of the MIECHV program and its evidence-based design by proposing increases in funding to capture more than just 3 percent of those children and families who could greatly benefit through the program's services?

Answer: I share your goal of increasing access to affordable, quality health coverage for rural America. While I cannot comment specifically on legislation that would reauthorize MIECHV, I look forward to working with you on examining this program's funding and working on ways to improve rural and child health using evidence-based approaches.

Diversity in Hiring

14. The Affordable Care Act expanded health care coverage to millions of Americans who were previously uninsured. Because of the greater demands on the health care industry, the ACA has also become an engine for job growth in the health related fields. This is especially true for women and people of color.

    For example, women represent 75% of the health care workforce. Nearly half of workers in the long-term/ residential and home health care services are people of color. The future of our American workforce in the health industry promises increasing diversity. Between 2003-04 and 2013 -14 the number of doctoral degrees conferred in health profession fields increased by 61 percent (from 41,900 to 67,400 degrees)[i]. In 2013-14, one third of those doctoral degrees were awarded to people of color.[ii] The importance of a diverse workforce in the health industry has been well-documented in scientific literature. One of the more significant outcomes of a diverse workforce is greater access to and quality patient care.[iii] Diversity in the workforce also increases career opportunities for people of color.

    Given the fact that the current administration intends on gutting the Affordable Care Act, which along with leaving millions of Americans uninsured will also leave thousands of women and minorities without an opportunity to build a career in their field of study:

    a. **Question: Will you commit to minimizing the impact of leaving thousands of incoming women and minority health care professionals without a career path to look forward to?**

       Answer: Workforce issues are a major challenge in healthcare. We should work together to expand career options and paths for all healthcare professionals.

    The Department of Health and Human Services is among the most diverse agencies to work for within the government, except when it comes to its Hispanic labor force. In FY2015,

Hispanics comprised 3.08% of HHS' workforce compared to 9.96% of the National Civilian Labor Force[iv].

b. **Question: What concrete steps does the Department of Health and Human Services plan to take to increase diversity and inclusion in its agency, especially at its Senior and Executive levels?**

Answer: If confirmed, I would be pleased to work with you to identify steps that could be taken to ensure the Department is drawing upon the widest and most diverse pool of applicants possible in the hopes of it resulting in an even more diverse workforce.

Diversity in Health Outcomes

15. Eliminating health care disparities among Americans from minority racial and ethnic backgrounds has long been a bipartisan issue. In 1985 under President Reagan, then Secretary of Health a Human Services Margaret Heckler commissioned a report on Black and Minority Health where she noted that there was a "continuing disparity in the burden of death and illness experienced by […] minority Americans as compared with our nation's population as a whole." The report, as she envisioned, should have marked "the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health."[v]

    Unfortunately that shadow is still cast over our country. There is a significant body of literature that indicates that disadvantaged populations, such as racial and ethnic minorities, still face systemic barriers to achieving ideal health. For example, African Americans are 50% more likely to die from heart disease or stroke; Asian/ Pacific Islanders are 60% more likely to have acute Hepatitis B, which causes liver disease; and African-American, Native Hawaiian/Other Pacific Islander, and Hispanic adults all have rates of HIV infection diagnosis that range from three to nine times the rate of non-Hispanic Whites[vi]. To that end, the Affordable Care Act established Offices of Minority Health within six agencies, thus expanding the work begun by President Reagan 30 years ago. The purpose of creating these offices was to have greater interagency coordination when it comes to eliminating minority health disparities.

    To the extent that this administration has taken and will continue to take concrete steps to repeal the ACA, which created the Offices of Minority Health within the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), and the Substance Abuse and Mental the Health Services Administration (SAMHSA):

    Question: Will you commit to prioritizing the elimination of minority health disparities in America a priority? Please provide specifics of how you plan to make this a priority.

    Answer: Health outcome disparities are a challenge and prioritizing work in this area is important. Using the proper metrics may provide important insight into new solutions.

Questions for the record from Senator Rob Portman

Question for the Record with Senator Brown

1. HHS, through CMS, has a long tradition of supporting nursing education. Our state of Ohio is home to 12 facilities that receive Medicare pass-through funding for nursing education. Over the past few years, CMS support for nursing education funding has been under threat due to accreditation changes. We have authored a bill, the MEND Act that would ensure CMS support of nursing education through pass-through funding continues and that we can continue educating high quality nurses.

   Question: If you are confirmed, will you commit to work with us in Congress to provide technical assistance and ensure that the MEND Act is quickly implemented if passed?

   Answer: I look forward to working with you on this issue and sharing both feedback and assistance regarding the important policy and technical issues in nursing education funding, an issue related to and similar to the challenges with physician shortages but broader in geographic scope and impact. If the law is implemented, and if confirmed, I will ensure it is implemented on the timeline Congress imposes.

Question for the Record with Senator Casey

2. Section 154 of MIPPA 2008 specifically excludes from the Medicare DME competitive bidding program (CBP) CRT power wheelchairs, as well as the accessories that consumers use with those wheelchairs. Consistent with the law, Congress did not include those CRT items in Rounds 1 or Rounds 2 of the DME bidding program and has repeatedly expressed to CMS that it was not the intent of the law to apply bid rates to accessories used with CRT wheelchairs. Unfortunately, CMS has interpreted MIPPA contrary to Congressional intent and in December 2014 CMS posted on-line a "Frequently Asked Questions" (FAQ) document stating that starting in January 2016 CMS intended to use bid pricing information obtained from the CBP for standard wheelchair accessories to reduce the payment amounts for CRT wheelchair accessories.

   At the end of 2015, Congress included in the Patient Access and Medicare Protection Act (PAMPA) a 12-month delay (through December 31, 2016) of CMS' planned application of CBP prices based on standard accessories to CRT accessories that share the same HCPCS code. In December 2016, as part of the 21st Century Cures Act, Congress included an additional 6-month delay that will expire on June 30, 2017.

   Question: Based on your support for this non-application of CBP prices to CRT accessories as a member of Congress, if confirmed as Secretary of HHS, can you commit to work with Congress to correct this CMS policy and adhere to the intent of Congress in MIPPA?

   Answer: As a member of Congress, I have been engaged in understanding and improving the competitive bidding program. If confirmed, I will continue this work but with the different role of carrying out the law for the benefit of the American people. If confirmed, I fully

expect to work with Congress on this issue and many others that arise when Congress' intent encounters the details of implementation. I also hope to bring to that role, if confirmed, the informative and valuable perspective of serving as a member of Congress writing and voting on these laws.

Questions for the record from Senator Benjamin Cardin

CMMI and Health Care Delivery Innovation

1. **Question: What are your views of state demonstrations, state innovation, and Centers for Medicare & Medicaid Innovation (CMMI) authority?**

   Answer: I believe these authorities can be important ways to ensure there is flexibility in CMS programs and activities for the individual and varying needs of states.

Drug Prices

2. Last year the country was shocked by a series of price-hikes on older, off-patent drugs by manufacturers who had played no part in the research and development that produced them. The Senate debated numerous solutions last Congress to prevent price gouging behavior and many put the ball squarely in HHS' court.

   Question: What is your view on HHS' role in preventing price-gouging and if confirmed, how do you propose to use the office of Secretary to ensure Americans have access to affordable prescription drugs?

   Answer: The issue of drug pricing and drug costs is one of great concern to all Americans. You have my commitment to work with you and others to make certain that Americans have access to the medications that they need. If confirmed, I look forward to focusing on how we can make health care more affordable, including prescription drugs. I share your concern regarding the importance of individuals and families being able to afford the prescription drugs they need.

Emergency Health Services

3. The Balanced Budget Act of 1997 requires Medicaid managed care organizations (MCOs), and others, to cover emergency services without prior authorization and established a federal "prudent layperson standard." This standard defines an "emergency medical condition" as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.

   a. **Question: Do you support this federal policy?**

      Answer: I appreciate the aim of this federal policy is to ensure a minimum level of emergency room coverage for Medicaid managed care organizations. Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and potential Medicaid managed care coverage requirements. While I believe that in the long run a one-size-fits-all approach is not workable for a country as diverse as the United States, my hope is to make sure that Medicaid beneficiaries need not rely on

the emergency room to reliably access care because they have a doctor they trust in their community and a strong relationship and reliable access to that doctor.

b. **Question: Will you ensure the Centers for Medicare & Medicaid Services continues to enforce the prudent layperson standard for all Medicaid MCOs?**

Answer: If confirmed as Secretary, I will faithfully implement laws written by Congress and the regulations issued by the Department. This includes enforcement action as appropriate. As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them.

Federal Workers

4. **Question: Do you believe that the Office of the Actuary's actuarial and economic projections should be based on "best professional estimates" and remain as free as possible from political considerations? Why or why not?**

Answer: In getting advice from any professional it is important that advice be objective and consistent with relevant professional standards. Just as I would expect that from any doctor I visit I would expect the same from an actuary.

Global Health Security Agenda

5. **Question: What are your views on President Obama's Global Health Security Agenda?**

Answer: In an interconnected world, no nation is safe from the risks posed by infectious diseases. I agree that the international community must continue to work together towards the common goal of a world safe from infectious diseases. I also agree that the international community must build-up our capacities in order to achieve this goal. If confirmed I will meet with the Office of Global Affairs and CDC to review the progress we have made on this agenda.

6. For decades the US government has been a leader in strengthening health systems around the world to prevent, detect, and minimize the impact of emerging infectious diseases. The United States is one of over 50 countries that have committed to the Global Health Security Agenda, which aims to help countries improve their capacity to prevent, detect, and respond to infectious disease outbreaks.

Question: As Secretary, how would you support and enhance global efforts to detect, prevent, and respond to diseases internationally to prevent them from becoming a threat to the US?

How will you ensure that we effectively address emerging crises and maintain our leadership role in global health?

Answer: No global effort to detect, prevent, and respond to diseases internationally can be successful without an active and engaged United States. Rapid response in fighting infectious diseases is essential. Oftentimes, we can ensure these diseases do not spread to our shores if we do what we can to stop them spreading abroad. Few responsibilities are more important than keeping the public safe from potential public health pandemics and if confirmed I will make this a top priority.

7. America's approach to global health has been extremely successful, including the effort to move toward ending the epidemics of AIDS, tuberculosis and malaria. The hallmark of America's work against the three diseases has been to support results-oriented, accountable and transparent programming through the Global Fund and bilateral programs including PEPFAR, PMI and the USAID tuberculosis program. The Global Fund and our bilateral programs closely coordinate their work and depend on each other to implement comprehensive programming.

   Question: As Secretary, will you be committed to continuing America's leadership against AIDS, TB and malaria through Global Fund investments?

   Answer: United States leadership has been crucial in fighting AIDS, TB and malaria. Should I be confirmed, I fully expect these efforts to continue as we build upon and learn from our past and current initiatives. HHS and CDC are critical to fighting a range of global health security threats from Ebola and Zika to polio and HIV/AIDS. Yet, as was made clear during the Ebola epidemic, severe shortages of health workers greatly hamper efforts for infectious disease prevention, detection and response.

8. HHS and CDC are critical to fighting a range of global health security threats from Ebola and Zika to polio and HIV/AIDS. Yet, as was made clear during the Ebola epidemic, severe shortages of health workers greatly hamper efforts for infectious disease prevention, detection and response.

   Question: In your view, what is the role of the Department of Health and Human Services in growing and developing a better-trained health workforce worldwide?

   Answer: If confirmed as HHS Secretary, I look forward to working with the health secretaries of other nations in helping the world community train an international health workforce capable of tackling the myriad public health challenges of the 21st century.

Graduate Medical Education (GME)

9. The current Medicare GME system is not producing enough doctors who will practice in rural America. Data show less than 5% of all graduates practice in rural areas. When

Congress set limits on the number of Medicare funded GME slots (BBA 1997) there was clear intent in both the statute and the report language to treat rural training differently and provide special consideration to meet the needs of underserved rural areas. Unfortunately, the technicalities of the statute, and the regulations deriving from it, have not succeeded in achieving this intent.

Question: What will you do as Secretary of HHS, specifically, to support changes to Medicare GME to increase the production of physicians practicing in rural areas?

Answer: I have always been a strong supporter of efforts to support medical education. Congress has used the Medicare program from its inception to invest in future generations of doctors. Regardless of what we do in Washington, health care should always be about that one to one relationship of a patient to a doctor. That relationship of course requires a doctor. And so I am hopeful we can continue to find ways to remove disincentives to the practice of medicine and its rewards as well as support the profession in other ways. This issue is all the more important in the case of a rural area, where there is already an ongoing physician shortage and difficulty in recruiting talent and capital for medical infrastructure. If confirmed as Secretary, I would look for opportunities to address these situations through GME but also through programs administered by the Health Resources Services Administration and by taking a closer look at telemedicine.

Medicare

10. Your ACA replacement proposal, the Empowering Patient's First Act, eliminates benefit expansions for beneficiaries such as free preventive benefits (blood pressure screenings, colorectal screenings and immunizations) and closing the Part D donut hole which helped with out-of-pocket prescription drug costs.

Question: If confirmed as HHS Secretary, how do will you prevent any care reductions for or our-of-pocket healthcare cost increases to Medicare beneficiaries?

Answer: In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

Mental Health Workforce

11. Mental health professions face chronic workforce shortages, and the future for many of these professions remain grim. For example, a recent survey from the American Association of Medical Colleges found that almost 60% of psychiatrists are aged 55 or older, making

psychiatry the fourth oldest medical specialty in terms of practitioner age.

Along with the overall shortage, the distribution of mental health practitioners heavily favors key urban and suburban areas of the country over rural regions. The 21st Century Cures Act requires the Substance Abuse and Mental Health Services Administration to develop a strategic plan every four years to identify strategies to improve the recruitment, training, and retention of a mental health and substance use disorder workforce.

While this provision and similar provisions are steps in the right direction, the numbers clearly suggest that growing a robust workforce to meet the mental health and substance use needs of nearly 70 million Americans will be of paramount importance in the coming years. Please describe in detail how you, if confirmed, will support the growth of the next generation of mental health practitioners.

What strategies will you use to encourage medical students and others to pursue careers in these fields?

Answer: It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. If I am confirmed, I look forward to working closely with you and the other members of Congress to faithfully execute the 21st Century Cures Act, which aims to ensure that the mental health profession is adequately staffed for current and the future generations.

Minority Health

12. In Maryland, the ethnic minorities make up roughly 41% of the state's population. This is important because the health outcomes of minority populations are significantly lower and morbidity rates are higher than that of majority populations. Your Department, HHS, recognized this when it produced with what is commonly called the Heckler Report back in the 1980s, under President Ronald Reagan, looking at what are now commonly called "health disparities" and the need for more health professionals coming from minority and underrepresented backgrounds.

    Racial and ethnic communities suffer disproportionate higher rates of illnesses, disabilities and preventable deaths. In fact, according to Johns Hopkins and University of Maryland researchers, racial health disparities cost the United States $229 billion between 2003 and 2006.

    Question: The Affordable Care Act is allowing communities coverage and access to much needed care, treatment and prevention services from diabetes, to cancer, to asthma and more. Specifically, how do you plan to further the elimination of racial and ethnic health disparities?

    Answer: I am committed to ensuring that minorities in this country have access to the highest quality care. To address these challenges, we need to examine what is happening on

the ground in these communities. From there, we can establish better metrics and better accountability, and I look forward to working with you on this when I am confirmed.

National Institutes of Health (NIH)

13. Young scientists in the United States are finding it more difficult – and more time-consuming – to secure stable funding to launch their research careers, which stifles America's competitiveness. More and more talented young people are dropping out of the scientific workforce or choose not to enter in the first place.

    Question: What do you plan to do to ensure barriers facing young scientists are addressed and can we count on your leadership to implement the recommendations that come out of the National Academies report?

    Answer: If confirmed, I will look at flexibilities given to us through the 21st Century Cures Act and the focus on "young emerging scientists" to better recruit and retain top talent in order to help us achieve our mission of promoting innovation in order to benefit patients and their families across the country.

14. **Question: What do you see as the future roadmap for NIH over the next four years?**

    Answer: If confirmed, I will work with NIH leadership to map out a forward-leaning NIH agenda. As I mentioned in my testimony, NIH is a true treasure for our country. With the increased resources provided in the Cures Act and the President's commitment to innovation and patient-centric healthcare, great opportunities lie ahead for the NIH.

Pediatric Dental

15. According to the CDC, tooth decay (cavities) is one of the most common chronic conditions of childhood in the U.S. and if left untreated, tooth decay can cause pain and infections that may lead to delays in important cognitive skills, such as eating, speaking, playing, and learning.

    Question: How will you plan to ensure that children will continue to have access to early prevention services for oral health?

    Answer: If confirmed as Secretary, I would hope to work with you to revisit the current CMS' "Oral Health Strategy" for children (https://www.medicaid.gov/medicaid/quality-of-care/downloads/cms-oral-health-strategy.pdf). I would also aim to provide states with flexibility in their Medicaid programs to provide both coverage and access to these services. Lastly, there may be opportunities to encourage innovation in both the coverage and payment for these services as well as the actual technology and even the relevant public health education strategies.

Social Services Block Grant (SSBG)

16. This important program funds a variety of social services programs, from child protection to elder abuse to Meals on Wheels. I see every day in Maryland how this grant program helps our neediest and most vulnerable citizens. You proposed eliminating this $1.7 billion a year program as the Chairman of the House Budget Committee.

    Question: What was your rationale for trying to eliminate this program, and what would you put in its place?

    Answer: During my time in Congress, I have been acutely aware of the need to eliminate duplicative programs and strengthen those programs that work. As a 2011 GAO report pointed out, SSBG is a program of fragmentation, overlap, and duplication. SSBG essentially offers no-strings attached approach and a blank check to states. However, as SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be so honored as to be confirmed as HHS Secretary.

Substance Use Disorders

17. The United States currently faces a growing epidemic in the form of prescription drug misuse, abuse, addiction and overdose. The numbers are disquieting. One person dies every 19 minutes from a drug overdose, now the leading cause of death among those ages 25-44, according to Johns Hopkins experts.

    In Maryland in 2015, fatal overdoses in the state were up 21 percent from the year before, and nearly twice the number in 2010. There is an urgent need for evidence-informed solutions ready for rapid implementation.

    Question: How will HHS balance the twin-priorities of preventing new cases of opioid addiction and expanding access to effective addiction treatment while safely meeting the needs of patients experiencing pain?

    Answer: The opioid epidemic is real. This epidemic is a rampant crisis that is harming families and communities across the nation. I firmly believe it is vital that those suffering from substance abuse have continued access to addiction treatment. If confirmed, I am committed to working closely with you and the other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of treating those who are in addiction recovery, and prioritizes prevention efforts to keep America's families and communities healthy.

18. Last month, the Centers for Medicare and Medicaid Services (CMS) granted Maryland a Medicaid Section 1115 waiver to implement initiatives to address substance use disorders throughout the state. This is great news for my home state and a first step to addressing opioid abuse and heroin use. Now, Medicaid enrollees will have access to residential treatment for substance use disorders, putting them on the road to recovery.

Question: If confirmed as HHS, will you commit to ensuring states' ability to use Medicaid Section 1115 models to provide life-saving care, including addiction treatment and recovery services covered by Medicaid, to Americans in need?

Answer: If I am confirmed, I will work with CMS and SAMHSA to help low-income adults with mental health and substance use disorders. With respect to Medicaid specifically, every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with states to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. Waivers are an important tool for states to innovate within the Medicaid program. If confirmed, I would work with CMS to ensure that it evaluates waivers like Maryland's on their merits, taking into account the desirability of states charting their own course, and ensure that they are compliant with the law.

Temporary Assistance for Needy Families (TANF)

19. I am concerned that, while the TANF caseload had declined by over 60 percent over the last 2 decades, the number of children in poverty and deep poverty (meaning income below half the poverty line) has increased.

    a. **Question: What steps would you take to reverse this trend?**

    Answer: If confirmed as HHS Secretary, I am going to do all I can to effectively and efficiently administer the laws passed by Congress to address and alleviate the very real problem of children living in varying levels of poverty.

    b. **Question: Do you agree that TANF is not succeeding as a program even if caseloads are declining while the number of persons in poverty and deep poverty are increasing?**

    Answer: Respectfully, I must disagree with this assessment of TANF's success. Since passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

Therapy Caps

20. As you know, the therapy cap exceptions process expires in less than a year—on December 31, 2017. We have all heard from constituents whose therapy needs exceeded the cap and their conditions have deteriorated, necessitating more expensive medical intervention.

Question: As Secretary of HHS how will you support the repeal of these arbitrary and discriminatory limits and maintain access to rehabilitation therapy that Medicare beneficiaries clearly need?

Answer: If confirmed as Secretary, I will look into this issue and seek to understand the competing objectives and issues motivating the current CMS policy. Part of the frustration with the current health care system is rules like this that do not make sense to many people. However, that is not surprising when one considers that Medicare Parts A, B, C, and D have each developed in silos and that even payment for particular types of services sometimes reflect silos within the silos. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed as Secretary, I would hope to break down these silos and encourage approaches based on a broader perspective.

21. **Question:** Given the problems associated with monitoring the therapy cap, are the Centers for Medicare and Medicaid capable of achieving a timely uniform and defensible streamlined, responsive, and transparent process for manual medical review of Medicare records by Medicare administrative contractors?

Answer: Any time there is manual review of anything in an organization with the scale of Medicare, there is a recipe for something to go wrong. If confirmed as Secretary, I would be pleased to work with you to confirm whether the staffing and other resources needed would be up to the challenge you describe.

Questions for the Record from Senator Dean Heller

Medicaid Expansion

1. **Question: Do I have your commitment to working with Congress, and members of this committee, to protect access to care for all patients in Nevada, particularly the over 600,000 Nevadans currently covered under Medicaid?**

   Answer: I am committed to ensuring that Medicaid is available for eligible beneficiaries, and working with states to ensure they are able to make the most use of available resources to serve their citizens, if confirmed as Secretary of Health and Human Services. Each state has different needs, and I believe CMS needs to work with states to ensure that, consistent with those needs, the Medicaid and CHIP programs provide the best possible coverage to their residents.

2. **Question: Under your leadership, how will the U.S. Department of Health and Human Services work with state likes Nevada, who expanded Medicaid, to ensure that they are successful in protecting access to health care, particularly the 200,000 newly eligible Nevadans, as we transition out of Obamacare?**

   Answer: I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

Doctor Shortage

3. **Question: Nevada is 47th in the nation for doctor to patient ratio. What can Congress and HHS do to attract more health care providers to practice medicine in rural and underserved areas in states like Nevada that are facing a significant doctor shortage?**

   Answer: If confirmed, I would work closely with the Center for Medicare within CMS to see that critical access hospitals are able to serve rural populations well. I would also work with the HRSA (Health Resources and Services Administration) Administrator to consider how CMS and HRSA can best cooperate with regards to community health centers and other issues. I would also consider how we can allow for reimbursement of telehealth in general and to further help address provider shortages.

4. **Question: Do you believe that tele-medicine would be helpful for predominantly rural states like Nevada expand access to care for patients in underserved areas?**

   Answer: Telemedicine is an exciting innovation that will allow for individuals to access resources that are otherwise not available. In the state of Georgia, we have a program that is a spoke and wheel program. There is a neurologist who works with a network of clinics and hospitals around the state. If somebody comes in with symptoms of a stroke, that neurologist is able to see the patient in real time and determine if they are having a stroke, whether they can be treated in the community or ought to be transferred. Innovations like this have been

particularly helpful for rural areas.

Financial Disclosure

5. **Question: To the best of your knowledge, as a member of the House of Representatives, did you fully comply with the Stop Trading on Congressional Knowledge Act (STOCK Act, P.L. 112–105) and the Office of Government Ethics (OGE) to publicly disclose your personal financial transactions?**

   Answer: To the best of my knowledge, I have met all compliance obligations for the disclosure of personal financial transactions by Members of the House of Representatives.

6. **Question: If confirmed, do you commit to fully complying with the law that would require you to sell stock in companies regulated by HHS?**

   Answer: If confirmed, I commit to fully comply with all applicable ethics and conflict of interest obligations required by law, including the divestment of all applicable securities identified for sale in my publicly-disclosed ethics agreement with the Office of Government Ethics ("OGE").

7. **Nevada State Legislature**

   Question: Please see the attached questions from the Nevada State Legislature. I respectfully ask that you respond to these important issues in the state, and cc Governor Sandoval.

   Answer: I look forward to writing to you and the Governor regarding these important issues. I expect my response will include the following:

   1. What steps do you plan to take to ensure that the more than 88,000 Nevadans who have purchased health insurance through the Silver State Health Exchange continue to have the ability to purchase health insurance with adequate coverage in a transparent marketplace?

   I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

   2. What steps do you plan to take to ensure that the more than 77,000 Nevadans who are eligible for federal tax credits under the Affordable Care Act to help purchase

private insurance will continue to have access to affordable health insurance options with adequate coverage?

I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

3. What steps do you plan to take to ensure that the 217,000 Nevadans who are receiving health care under the Medicaid expansion remain covered?

Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

4. The Affordable Care Act guarantees coverage vital to preventative services for women, including cancer screenings and birth control. What steps do you plan to take to ensure that the Affordable Care Act's coverage guarantees remain intact for women's health?

My hope is to move in a direction where insurers can offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans. And note that I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

5. The Affordable Care Act guarantees that Nevadans with pre-existing conditions will not be denied health care and ends lifetime minimums on coverage. It also allows younger people, many of whom are saddled with college debt and cannot afford insurance, to stay on their parents' insurance until they are 26. What steps do you plan to take to preserve those coverage guarantees?

Nobody ought to lose insurance because they get a bad diagnosis. As to coverage until age 26, the insurance industry has applied that across the board. In any case, if confirmed as HHS Secretary, my role would be to implement the replacement passed by Congress and signed by President Trump. Regardless of my own ideas, it is Congress that will ultimately decide what a replacement bill will look like, and my job would be to faithfully execute the law as passed by Congress.

Questions for the Record from Senator Michael F. Bennet

1. The Medicare Advantage program has been used to provide quality, affordable health care to about 18 million seniors and individuals with disabilities. Many of these seniors indicate that they are satisfied with their choice of Medicare Advantage program. In fact, 36% of Coloradans are in Medicare Advantage plans**.**

   Question: In your role as Secretary of HHS, how do you plan to support Medicare Advantage plans? What other steps do you plan to take to ensure that seniors have access to coordinated care plans?

   Answer: Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. If confirmed as Secretary, I would seek to ensure Medicare Advantage remains a stable option for beneficiaries and that Medicare Advantage plans are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want.

2. According to the Medicare Boards of Trustees, the Affordable Care Act (ACA) has extended the solvency of the Medicare hospital insurance trust fund by 11 years in total. The Committee for a Responsible Federal Budget estimates that a full repeal of the ACA would push up the insolvency date to 2021 and more than triple the program's 10-year deficit.

   Question: **How would you structure an ACA replacement bill that does not reduce the solvency of the Medicare Hospital Insurance Trust Fund?**

   Answer: Neither President Trump nor I are wedded to a particular plan to the exclusion of all others. We are looking forward to giving the American people what they've been longing for, for seven long years: real healthcare reform. But they have never wanted Obamacare: It has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship. A replacement need not affect the Medicare trust fund if the provisions related to Medicare are ones that are carefully considered.

3. **Question: Do you plan to advise the Administration to advocate for premium support as a means of extending the Medicare trust fund?**

   Answer: One of my goals in discussing these matters is to lower the temperature regarding what we are talking about. These issues have real-life impact for folks in their lives and so, if confirmed, I would advise the Administration that we convey to the Medicare population that they do not have reason to be concerned and that we look to assisting them in getting the care they need and the caregivers that they need too.

4. Colorado has 2.3 million people living with a pre-existing condition that rely on the protections of the ACA to receive coverage.

   Question: How would your plan keep coverage for pre-existing conditions and control costs while dissolving other parts of the ACA such as the individual mandate, the exchanges, and Medicaid expansion?

   Answer: Our goal is to ensure every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage. If we preserve the patient-doctor relationship and put the patient at the center, then we will see quality go up and costs go down. In any case, I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed.

5. I have heard from rural hospitals in Colorado that may lose significant funding if the ACA is repealed. The Medicaid Expansion provided some financial stability to hospitals that were on the brink of closure before the bill was passed. In fact, hospitals in Colorado saw a 30% drop in uncompensated care.

   Question: What metrics would you use to ensure that an ACA replacement does not hurt rural or critical access hospitals?

   Answer: Our goal is to ensure every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage. This of course includes individuals who access care at rural or critical access hospitals. And so the best metric in the end is one that measures the extent of access to actual care, not just coverage and the quality of that care as determined by patients working individually with their doctors.

6. You have included health savings accounts in previous proposals to replace the ACA. As you know, health savings accounts are essentially a way for people to save their own money that they can then spend on health care. They are not a substitute for quality coverage and are paired with a high deductible, making it difficult to obtain health care.

   Question: How can a middle class family making $60,000 a year successfully use a health savings account if they live paycheck to paycheck and can't afford to set aside thousands of dollars to pay for their health care bills?

   Answer: Our goal is to ensure every single American has to access to affordable coverage they want for themselves and their families. Health savings accounts are powerful tools that can be used to help lower costs and empower individuals, providing greater flexibility to spend health care dollars as they see fit.

7. The ACA took steps to enhance price transparency of health care services by requiring health plans to be more explicit about what they cover. A knee replacement in the U.S. could cost $11,000 in one area of the country and nearly $70,000 in another area. Consumers are still largely unaware of what they will be billed after a certain test or procedure.

   Question: What steps do you plan to take as HHS Secretary to improve price transparency for consumers?

   Answer: If confirmed as HHS Secretary, I would work to improve price transparency to foster and facilitate patient choice. In so doing, I would be focused on actual costs and not costs billed to insurance companies or from a master price list no one uses. At the end of the day though, until patients rather than government are making the purchasing decisions, the price transparency information we might aim to provide is of limited utility because it does not reflect the patients' collective choice and willingness to pay but the government's.

8. I worked with Senator Portman to introduce the Medicare PLUS Act which would set up a pilot program to help the top 15% of the highest-cost Medicare beneficiaries by coordinating their health care needs. As you may know, 15% of Medicare beneficiaries have six or more chronic conditions and account for 50% of total Medicare spending.

   Question: What steps will you take as HHS Secretary to pilot this program and ensure that these patients get the coordinated care they need?

   Answer: If confirmed as Secretary, I would explore what voluntary options we can make available to the Medicare beneficiaries with the greatest needs and their physicians. I think many will appreciate the opportunity to work with a care manager and possibly others who will spend the time and effort needed to help the patient make different choices to manage their own care. I would seek to work with you on your proposal to explore how it and others like it can be a path to empowering those who are subjected to the most uncoordinated and challenging aspects of our health care system.

9. Congress and the last Administration have made it a priority to pursue delivery system reforms that improve quality and lower costs. The Advancing Care for Exceptional (ACE) Kids Act, on which I worked with Senator Grassley, aims to coordinate care for vulnerable children with complex medical conditions.

   Question: What steps will you take as HHS Secretary to promote increased emphasis on reforms that target the needs of children with complex medical conditions?

   Answer: If confirmed as Secretary, I would look across the Department to identify all the ways in which HHS aims to help these children in need. And I would hope to encourage our use of existing authorities and funding to better align resources to meet this challenge. I would also work with members of Congress on their ideas on this important topic.

10. Over 500,000 children in Colorado are enrolled in Medicaid. Nationally, the program covers over 30 million kids.

    Question: If Medicaid is transformed from an entitlement program to a block grant, can you guarantee that those children will maintain coverage? What metrics will you use to ensure that those children are covered and have access to the same services that they do today?

    Answer: It is important that every child has access to high-quality health coverage, and Medicaid plays an important role in accomplishing this objective. If confirmed as Secretary, my goal would be to ensure that no child in Colorado or anywhere else is left behind.

11. The Children's Health Insurance Program (CHIP) currently covers 60,000 children in Colorado, increasing access to routine check-ups, prescriptions, and emergency services for vulnerable kids. Extension of the program needs to occur early this year in order for states to plan and have budget certainty.

    Question: What is your position on CHIP? What reforms would you recommend as HHS Secretary before supporting extending the program?

    Answer: It is important that every child has access to high-quality health coverage, and CHIP plays an important role in accomplishing this objective. CHIP plays a major role in this, but there is also a need for coordinated family coverage in the private market and employer plans, and giving states the needed flexibility.

12. The National Health Service Corps Loan Repayment Program has been vital in supporting primary care providers who then practice in Health Professional Shortage Areas (HPSAs). The ACA expanded this program and it has added necessary primary care providers in Colorado.

    Question: If confirmed as HHS Secretary, will you recommend that Congress support this program to increase the number of primary care providers in rural and underserved areas?

    Answer: As a physician, I understand the value and importance of the National Health Service Corps (NHSC) and the NHSC Repayment Program. I have included loan forgiveness for primary care providers in past legislative proposals, and I look forward to working with Congress on this issue when I am confirmed.

13. **Question (on behalf of Senators Bennet, Casey, and Brown): The Pharmacy and Medically Underserved Areas Enhancement Act recognizes pharmacists as health care**

providers in underserved areas in order to expand access to care. In areas with a shortage of primary care providers, pharmacists may play a key role in helping patients manage their diseases to avoid Emergency Department visits and hospitalizations. These services are especially important for patients with multiple chronic conditions who may be taking several medications at a time. As HHS Secretary, would you support this approach as a way to increase care in rural and underserved areas?

Answer: We ought to step back and say "What are we doing wrong?" as one of out every eight physicians no longer sees Medicare patients. Therefore, if confirmed as Secretary, I would be open to all options to address the impact of the ongoing physician shortage in rural areas. Paying pharmacists in underserved areas to engage in certain medical services could work well in those states where pharmacists have such licensure and a setting appropriate to the services, where primary care doctors continue to be involved in care, and where there is a patient and consumer demand for such services.

Questions for the Record from Senator Brown

Medicaid Expansion

1. During your testimony in front of the Senate HELP Committee last week, you told Senator Murkowski that Medicaid is an absolutely imperative program. You also said, in a response to one of Senator Young's question, that Medicaid is a program where "the states know best how to care for their Medicaid population."

   I agree that every state's role in the Medicaid program is significant, which is why I want to protect state flexibility when it comes to this program. Thirty-one states – including my home state of Ohio – have made the decision to expand Medicaid coverage under the Affordable Care Act (ACA).

   Ohio's Governor John Kasich, in a letter to Senator Hatch just last week, wrote "we strongly recommend that states be granted the flexibility to retain the adult Medicaid coverage expansion and federal matching percentage."

   Governor Kasich's letter also said that those states that have opted to expand Medicaid are experiencing significant positive results. In Ohio, high-cost ER utilization has gone down, health status has improved, and most enrollees have found it easier to keep or find work. Further, thanks to ACA's Medicaid expansion, Ohio was able to extend coverage to 700,000 previously uninsured Ohioans.

   Question: Do you support the flexibility provided to states under the ACA to expand Medicaid?

   Answer: State flexibility is an important component in making Medicaid more workable for patients. Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time to working to help identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States.

2. **Question: As a cabinet-level advisor to the President, how will you advise the President on any bill that would limit a state's flexibility to expand Medicaid – like Ohio did – as provided for under the ACA?**

   Answer: I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. Furthermore, I am committed to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

3. As part of the Medicaid program in Ohio, Governor Kasich has led efforts to engage providers, payers, community organizations, and employers and encourage them to work with the Medicaid population and provide a ladder out of poverty. As a result, more than 70% of the expansion population in Ohio reports that, since getting covered, it has been easier for them to keep or find a job.

   One program in particular, CareSource's Life Services pilot program provides supports and mentoring to help individuals achieve physical and behavioral health and economic stability. The CareSource Life Services program could serve as a national model for lifting individuals out of poverty.

   Question: As Secretary of Health and Human Services, how will you work to support and expand funding for programs like Life Services?

   Answer: I understand that some enrollees in CareSource's Medicaid managed care product have access to a program called Life Services which provides services and supports to help the enrollees obtain and keep jobs. Although I understand this Life Services program is a benefit of the managed care plan and not part of an Ohio Medicaid 1115 waiver demonstration, I would be interested to explore with you and others how such programs might be integrated or associated with a Medicaid waiver. This kind of development shows why waivers are an important tool for states to innovate within the Medicaid program, as they have for many years prior to the ACA becoming law.

Medicare Negotiations/Drug Prices

4. Last week when you testified in front of the HELP Committee, you were also asked how we should address the high cost of prescription drugs.

   You avoided answering questions from many of my colleagues by saying that, as Secretary of HHS, your job will be to "administer" programs and not "legislate."

   President Trump supports the elimination of the noninterference clause in Medicare Part D. He would like to have the Centers for Medicare and Medicaid Services (CMS) negotiate directly with drug manufacturers to get the best deals on prescription drugs for our nation's seniors.

   Question: If Congress passes legislation supported by the President that gives the Secretary of HHS the authority to negotiate and this legislation is signed into law – would you use this administrative authority to negotiate better prices on behalf of the more than 40 million Part D beneficiaries?
   What are your ideas on effective ways to reduce out-of-pocket prescription drug costs for Medicare beneficiaries?

   Answer: We all share concern when prescription drug prices are too high for anyone to access the drugs they need. This especially concerns me as a doctor**.** If confirmed, I look forward to using tools Congress provides to lower healthcare costs. In addition, we need to

continue to build on the gains towards affordability allowed by the Generic Drug User Fee Act and find additional ways to facilitate more efficient generic entry. This starts with making sure that we are giving generic sponsors clear guidance so that they can prepare approvable applications on the first try. If I'm confirmed, I'm committed to working with the FDA (and Congress, if appropriate) to find additional efficiencies and administrative steps that can help facilitate appropriate generic entry.

Fair Pay/Homecare Workers

5. The majority of the home care workforce – or those individuals who provide services to older Americans and individuals with disabilities who receive home and community-based services through Medicaid – is made up of female workers.

   This workforce is primarily paid through Medicaid and, on average, states pay these workers an average of just $13,000 a year. This means that those women caring for the disabled and elderly are often forced to rely on Medicaid themselves.

   In order to provide the highest level of quality care to our most vulnerable Americans – the elderly and those with disabilities –
   Question: Do you agree that those home care workers providing this care full time should be paid more than $13,000 a year by their state Medicaid program – yes or no?

   Answer: I agree it is important to provide those who care for our most vulnerable total compensation that reflects the important work they do. In many cases, this compensation may include more than wages and could, depending e.g. on housing prices, be significantly more than the number given.

6. Past leadership at CMS committed in writing to exploring federal actions under its current authority that could work with states to strengthen and support home care workers. In a meeting with Finance Committee Staff last week, you expressed an interest in building off of the work of the prior Administration.

   Question: Will you commit to continuing this work to ensure fair pay and advancement opportunities for the home care workforce. Describe how you would go about achieving this goal.

   Answer: If confirmed, I would be pleased to work with you to explore such options. One potential issue is to ensure that such workers are not somehow considered state employees and therefore subject to unique requirements and diversions from income that relate to that labor workforce. Another longer term situation is to empower patients, as the ultimate recipient of these services to make choices regarding providers of these services that leads to a competitive market for higher performing workers who satisfy customers.

Infant Mortality/ Tobacco

7. Ohio has one of the highest infant mortality rates in the country. In 2015, our state ranked 42nd in the nation for infant mortality, and even worse for African American babies.

   We don't know exactly why Ohio does so poorly when it comes to infant mortality, but one thing that we do know is that health complications caused by preterm births are the leading causes of infant mortality. We also know that a major factor in premature births is tobacco use, and Ohio's smoking rate among pregnant women is nearly twice the national rate.

   In addition to providing coverage to an additional 20 million Americans, the Affordable Care Act also strengthened Medicaid coverage of services that help tobacco users to quit. Local groups have taken advantage of these provisions in their fight against infant mortality.

   Question: Medicaid covers nearly 50 percent of births in this country. Do you support the current requirement that state Medicaid programs provide pregnant women with effective tobacco cessation services without cost sharing?

   Answer: The science is pretty clear that tobacco use during pregnancy is risky for both moms and babies. States should have maximum flexibility to prioritize critical health risks such as smoking during pregnancy. When it comes to Medicaid requirements, I hope to return a lot of control to States, and if confirmed, I will be reviewing such requirements and their efforts in order to develop policy recommendations for reform.

8. **Question: How will you work with Congress to maintain this requirement so that all pregnant women – regardless of their income – has access to tobacco cessation services?**

   Answer: The science is pretty clear that tobacco use during pregnancy is risky for both moms and babies. Availability of cessation programs is important. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. Regardless, I commit to work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

Infant Mortality

9. As I mentioned in the hearing and in my question above, the infant mortality rate among African American infants in the state of Ohio is among the worst in the United States. The overall rate of infant mortality in Ohio is 42nd in the nation. I have introduced legislation to improve prevention efforts nationwide by improving federal reporting of infant and childhood deaths, putting the power in the hands of the Secretary of HHS to generate the metrics by which these incidences are reported.

Question: As Secretary of HHS, how would you work to ensure adequate funding for the issue of infant mortality, and which metrics and protocols would you use to improve reporting of infant mortality cases across the country?

Answer: Infant mortality is a serious concern for our nation. While many of the underlying factors that contribute to infant mortality are poorly understood, we know that certain health behaviors, including alcohol consumption and tobacco use during pregnancy, have contributed to higher rates of infant mortality in the U.S. Access to prenatal care is also vitally important.

If confirmed as Secretary of HHS, I would work to examine the range of HHS programs, including research to prevent infant mortality, programs to prevent child abuse and neglect, efforts to increase access to health services for low-income pregnant women and infants, childhood vaccination initiatives, home visitation programs, and other initiatives across the Department to ensure these resources are used more effectively to address this issue and, if necessary, seek additional funds.

Regarding metrics used to report infant mortality, I agree that measurement is extremely important as we tackle this problem. I intend to work with the Congress and within the Department to bring more consistency and accuracy to how we measure infant mortality.

Medicare Part D/ DIR Payments

10. As you know, community pharmacies serve on the front lines as health care providers and play an integral role as part of the Medicare Part D benefit. In recent years, however, pharmacies have faced increasing uncertainty in their ability to serve Medicare beneficiaries due to the increasing use of post-claim adjudication price concessions and fees imposed by pharmacy benefit managers, called Direct and Indirect Remuneration (DIR) fees.

    CMS has recognized issues with how DIR fees are reported by part D plan sponsors, how these fees impact pharmacy business, and the resulting challenges they create for Part D beneficiaries. To respond to these issues, CMS proposed guidance (*Proposed Guidance on Direct and Indirect Remuneration and Pharmacy Price Concessions*) to standardize the timing of how these fees are reported on September 29, 2014. This proposed guidance would help pharmacists better serve Part D beneficiaries by providing greater clarity about their reimbursement when medications are dispensed and would benefit beneficiaries in that they would be able to make more accurate comparisons in plan selections.

    Question: Will you commit to supporting the finalization of such guidance? Are there other things you would do to ensure pharmacies have the information they need – in real time – to best serve their beneficiaries? If so, what are they?

    Answer: If confirmed, I will look forward to working with you to consider how to resolve this pending guidance issue. Incidentally, I understand that on January 19, 2017, CMS

released a fact sheet with information about recent trends in drug costs and Direct and Indirect Remuneration (DIR) under Medicare Part D.

EPSDT

11. Identifying and treating conditions early in life—during childhood—before they become expensive long-term liabilities, is not only the right thing to do, but also cost effective. In 1967, Congress added a guaranteed benefit for children in the Medicaid program called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

    To this day, EPSDT continues to guarantee that children in the Medicaid program are appropriately screened and given the necessary treatments they need to thrive. If Medicaid were turned into a block grant—and existing federal standards were cut back—EPSDT would be at serious risk, and child health would be put in jeopardy.

    Question: Are you committed to maintaining EPSDT as a guaranteed benefit for children in the Medicaid program?

    Answer: Children are, and will continue to be, a high-priority population within the Medicaid program. States are well-positioned to determine the most appropriate ways to ensure access to the highest quality care for children, which includes diagnosis and screening procedures and the illnesses and conditions they uncover.

12. **Question: What are the most important metrics in evaluating the success of the EPSDT program?**

    Answer: From a clinical perspective, successful diagnosis and screening procedures are determined by how well they identify illnesses and conditions. Successful treatment of those illnesses and conditions is best evaluated by the extent to which the patient's care goals are achieved.

13. **Question: If confirmed, how will you use your authority to make sure EPSDT remains an effective program in ensuring children's health through Medicaid?**

    Answer: I look forward to working with states interested to advance initiatives designed to improve the quality of care provided to all Medicaid members, especially children.

14. Through the creation of the EPSDT benefit, Medicaid solidified dental services as a necessary component of coverage for low-income children and adolescents. Similarly, Congress recognized the need to include dental coverage as a requirement in the second iteration of the Children's Health Insurance Program (CHIP). The ACA then built on these two programs, and now pediatric dental coverage and preventive oral health services are included in many private insurance packages. Despite these advances, tooth decay remains

the most common chronic condition among children.

Question: How would you ensure that any major health reform efforts appropriately prioritize children's oral health, both in terms of benefits and affordability?

Answer: If confirmed as Secretary, I would hope to work with you to revisit the current CMS' "Oral Health Strategy" for children (https://www.medicaid.gov/medicaid/quality-of-care/downloads/cms-oral-health-strategy.pdf). I would also aim to provide states with flexibility in their Medicaid programs to provide both coverage and access to these services. Lastly, there may be opportunities to encourage innovation in both the coverage and payment for these services as well as the actual technology and even the relevant public health education strategies.

Medicaid Payment Parity

15. On average, Medicaid pays providers about 70 percent of what a Medicare provider receives for the same service. The only difference is the age of the patient being served. There are 45 million children enrolled in Medicaid and as you noted in your hearing, and inappropriately low Medicaid payments impede the ability of providers to accept more patients – both pediatric and adult – covered through this program.

    Along with Sen. Murray, I have worked to introduce the Ensuring Access to Primary Care for Women and Children Act in past Congresses, legislation that would solidify parity between Medicare and Medicaid reimbursements for primary care.

    In today's hearing, you mentioned that only one-in-three providers accept Medicaid patients. You cannot deny that lower Medicaid reimbursements is a contributing factor to this issue.

    Question: This is a platform in which the HHS Secretary can take a stance and move legislation forward. Do you believe that a child's care should be valued at only 70 percent of that of an adult?

    Answer: A child's care should not be valued at only 70 percent of that of an adult. The current Medicaid payment system is an inelegant combination of base rates set by states, supplemental payments to providers, and other federal and state funding sources for care to the Medicaid or uninsured populations.

16. **Question: If confirmed, how will you work to improve access to care under Medicaid by adequately and equitably reimbursing physicians that treat Medicaid patients?**

    Answer: I agree that adequate Medicaid reimbursement is essential to ensuring care for some of our most vulnerable citizens, and I look forward to working with Congress to accomplish this important objective.

Lead

17. **Question: Dr. Price, do you believe that there is no safe level of lead in children's blood?**

    Answer: Science should guide our conclusions in this area. If confirmed, I look forward to working with you to ensure safe environments for America's children.

18. The CDC very recently lowered its reference level for public health intervention for elevated childhood blood lead levels from 5 to 3.5 micrograms per deciliter**.**

    Lead is a neurotoxin, and exposure to it can have devastating lifelong consequences for children. Ohio is one of 29 states receiving funding from CDC for a state-wide lead poisoning prevention program. In 2014, almost 6,000 children under age six in Ohio, or 3.85% of those tested, had elevated blood lead levels.

    Question: If confirmed, will you keep the CDC's lowered lead reference level?

    Answer: If confirmed, I pledge to work with our public health specialists at CDC and throughout the Department to learn more about the impact of lead poisoning and communicate the dangers to families and communities.

19. **Question: At the end of 2016, CMS committed to developing and improving a targeted blood lead screening policy to ensure more children eligible for EPSDT benefits are tested. Can you commit to continuing this work and improving coordination across federal agencies to enhance our lead screening and treatment policies and achieve better outcomes?**

    Answer: If confirmed, I commit work to improve coordination across federal agencies to enhance our lead screening and treatment policies to achieve better outcomes.

20. **Question: What additional actions would you have HHS take to reduce the number of American children with elevated blood lead levels?**

    Answer: If confirmed, I pledge to work with our public health specialists at CDC and throughout the Department to learn more about the impact of lead poisoning and communicate the dangers to families and communities in order to reduce the number of American children with elevated blood lead levels.

Temporary Assistance for Needy Families (TANF)

21. As part of welfare reform, Congress restructured the Temporary Assistance for Needy Families – or TANF – program as a fixed block grant. Evidence shows that one effect of turning TANF into a block grant program has been that states are spending less and less on TANF programs and instead using these federal dollars to support gaps in state budgets. This change has resulted in more Ohioans who struggle to support their families with earnings below the poverty level.

Question: What does that say about other proposals to block grant programs like Medicaid? Do you think that the block grant approach should be a model for other safety net programs?

Answer: While this would ultimately be a matter for Congress to decide, I have long supported states finding their own solutions in addressing unique or complex situations in their states.

22. In November 2015, the state of Ohio asked HHS for a TANF waiver that would have 1) removed the distinction between "core" and "non-core" hours, 2) increased the vocational education training limit from 12 to 36 months, 3) increased the job search and job readiness time limit from six to 12 weeks and removed the four consecutive week time limit, and 4) removed the 16 hour monthly cap on good cause hours credited towards work participation (while maintaining the 80 hour annual cap). HHS never acted on this request.

Question: Given that this application has the support of Governor Kasich, if confirmed as HHS Secretary, would you grant this waiver to the state of Ohio?

Answer: In 2012, GAO responded to a congressional inquiry about an ACF Information Memorandum inviting states to apply for waivers to the TANF work requirement. GAO concluded that the Information Memorandum was a rule that must be submitted to Congress and the Comptroller General before taking effect. If confirmed as HHS Secretary, I will enquire about the status of this matter and the waiver request from the state of Ohio, and provide a response if one has not previously been sent.

Medicare Observation Status/ Three-Day Rule

23. Instead of privatizing Medicare or raising the eligibility age, we should be discussing ways to make Medicare stronger for our nation's seniors. One way to strengthen the program – which you brought up in today's hearing – is to enable beneficiaries better access to skilled nursing facilities after hospitals stays by revisiting the three day rule.

In order for Medicare Part A to cover skilled nursing facility care, a beneficiary must be admitted to a hospital for three days under inpatient status. I have heard from too many Ohioans whose skilled nursing facility care was not fully covered by Medicare because their hospital stays were classified as "observation" rather than inpatient.

My *Improving Access to Medicare Coverage Act*, which I plan to reintroduce this Congress, which would enable time beneficiaries spend in the hospital under observation to count toward the three-day requirement for Medicare coverage.

Question: If confirmed, will you work to administratively correct this billing technicality that adversely impacts Medicare beneficiaries? If you are unable to do so administratively, will you work with me to pass this legislation to correct the deficiency

in current law?

Answer: If confirmed, I will be pleased to work with you to further consider the necessity of the three day rule and its pros and cons. I will endeavor to work with CMS to identify what more can be done with regard to the observation status issue as well. And if the best path forward involves legislation, I would be pleased to work with you on that as well.

Biosimilars

24. Last year, a number of my colleagues and I sent a letter to then President-elect Trump, encouraging him to work with us on reducing prescription drug prices for all Americans. Specifically, we highlighted the need to promote innovation and foster competition in drug development.

    I have introduced legislation in the past that would help achieve this by shortening the patent exclusivity period for expensive, brand-name biologic drugs and allow biosimilars to enter the market sooner. Biosimilars, which are equivalent in safety and efficacy to their reference biologics, have the capacity to reduce prescription drug costs, yet physicians must be willing to prescribe them and patients need the information necessary for them to be confident in taking them.

    Question: As a physician, do you believe physicians and patients understand what biosimilars are and how they work? Do you believe the patients and physicians see biosimilars as a safe, effective, and less-costly alternative to biologics?

    What do you believe to be the FDA's role in educating patients, providers, and other stakeholders about biosimilars? How will you, as Secretary of HHS, support and encourage the robust uptake of biosimilars in the U.S.?

    Answer: As a doctor, I appreciate your concern that health care providers and patients be informed when making health care decisions. It is important that the FDA provide clear and timely guidance as it carries out its responsibilities with respect to biosimilars. I understand that this is particularly important given that the number of biosimilars available to consumers is expected to increase and the potential that these products have to increase consumers' health care options.

Cost-Sharing

25. More than 25 years ago, Congress implemented protections to ensure that Medicare beneficiaries are treated and billed fairly by their providers in response to growing concerns that patients charged more than the standard 20% Part B coinsurance were opting out of critical care due to high out-of-pocket costs. However, while you were in Congress, you backed legislation that would have weakened these protections, allowing Medicare providers to enter into private contracts with seniors and people with disabilities to determine cost sharing amounts.

Question: Do you maintain your position that these patient protections should be undone and will you continue to advocate for permitting doctors who serve seniors to charge them more than 20% over what Medicare pays, your concern being that those limits compromise access to care for seniors?

Answer: If there are any program changes in this area, they should be voluntary for both patient and physician.

26. **Question: Do you believe that Medicare doctors should be allowed to charge patients whatever they choose?**

    Answer: If there are any program changes in this area, they should be voluntary for both patient and physician.

27. **Question: What would you say to fixed-income seniors who receive unexpected additional costs simply so that physicians can be paid more than the agreed-upon insurance coverage limit? Is this not putting patients above profits?**

    Answer: Our goal is to ensure all Medicare recipients are able to obtain the highest quality healthcare. If there are any program changes in this area, they should be voluntary for both patient and physician.

State Health Insurance Assistance Programs (SHIPs)

28. The State Health Insurance Assistance Programs (SHIPS) are the only source of one-on-one Medicare counseling for seniors and people with disabilities. In 2015, over 7 million people with Medicare received help from SHIPs, including 375,000 Ohioans using the nation's best-ranked SHIP program in the country. Since 1992, counseling services have been provided via telephone, one-on-one in-person sessions, interactive presentation events, health fairs, exhibits, and enrollment events. Individualized assistance provided by SHIPs almost tripled over the past 10 years.

    This modest program is operated in every state and U.S. territory, and has been significantly under-funded for years despite the growing demand for services by our nation's seniors and individuals with disabilities.

    Question: Will you pledge to support increased funding for SHIPs as the country's Medicare-eligible population continues to grow in the President's proposed budgets?

    Answer: If confirmed, I will fairly consider the needs and work of the SHIPs in light of a growing Medicare population, as well as consider other ways to support them to make them even more efficient. SHIPs and others like them play an important role in making sure patients are actual health care consumers. This is a virtuous cycle because it facilitates putting the patient at the center of both health care and health care coverage decision-making.

Drug Pricing

29. In December, President Trump told Time Magazine, "I'm going to bring down drug prices. I don't like what has happened with drug prices."

    Question: Do you agree with President Trump? If confirmed as Secretary of HHS, will you work to bring down drug prices?

    Answer: Yes. We all share concern when prescription drug prices are too high for anyone to access the drugs they need. This especially concerns me as a doctor. If confirmed, I will ensure that CMS looks for ways to ensure that it uses the authorities and tools it has at its disposal to ensure drug prices in the Medicare program, in both part B and part D, are manageable for beneficiaries.

30. **Question: Given the significant burden prescription price tags have on individuals and taxpayers, what do you see as the best market-based solution to combat prescription drug price gouging?**

    Answer: In addition, we can need to continue to build on the gains towards affordability allowed by the Generic Drug User Fee Act and find additional ways to facilitate more efficient generic entry. This starts with making sure that we are giving generic sponsors clear guidance so that they can prepare approvable applications on the first try. If I'm confirmed, I'm committed to working with the FDA (and Congress, if appropriate) to find additional efficiencies and administrative steps that can help facilitate appropriate generic entry.

31. **Question: Do you believe that Americans deserve more information about when and how prescription drug prices rise so that they can make the most informed decisions for their families?**

    Answer: Yes. I support empowering patients by putting more information in their hands so they can make health care consumer choices that make sense for them and their families.

Office of Refugee Resettlement

32. The Secretary of HHS responsible for overseeing the Office of Refugee Resettlement at HHS. This office is in charge of providing for the basic needs of refugees when they first arrive in the United States, including victims of human trafficking, torture survivors, individuals who are granted asylum, and those who are resettled here after helping our troops abroad because it is no longer safe for them in their home country.

Question: If confirmed, what will you do to ensure these necessary services are provided despite a significant lack of funding for this program? What are your plans for this office?

Answer: The law is clear when it comes to administering services for refugees, survivors of torture, and other populations who receive assistance through ORR. If I am confirmed, I will work to effectively and efficiently administer this Office.

33. **Question: Will you advocate for additional resources for this office, given the current refugee crisis across the globe?**

Answer: Should circumstances on the ground change, and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

34. **How will you work with our partners around the globe to ensure a safe and smooth transition for refugees coming into the U.S.?**

Answer: Should I be confirmed, it would be my expectation to work with the U.S. Department of State, as well as our partners around the globe, to ensure a safe and smooth transition for refugees coming into the U.S.

Center for Medicare and Medicaid Innovation (CMMI)

35. **Question: You've stated that you support innovation and see potential in CMMI. Would you support continued testing through CMMI in its current form?**

Answer: CMMI is a program providing significant opportunity for testing new models for healthcare financing and delivery. I defer to the Congress regarding the funding of the Innovation Center and any ACA repeal and replacement legislation. If confirmed, as HHS Secretary - and if the Innovation Center remains funded - I will ask CMS to pursue models that will lower healthcare costs and improve quality for Medicare and Medicaid beneficiaries.

Accountable Care Organization (ACO)

36. Many hospitals, physicians, nursing facilities, and others have invested significant resources to participate in ACOs and bundled payment systems. Ohio is home to some of the largest ACOs, by membership, in the nation.

Question: How would you respond to the concerns of ACO administrators and providers that there may be delays or disruptions in their innovative models due to a repeal of the ACA?

Answer: If confirmed, I am committed to working with all providing healthcare to incentivize innovative models for care financing and delivery.

37. **Question: Do you support the continued implementation of the current voluntary models – ACOs and bundled payment models?**

Answer: In general, yes. I look forward to reviewing all models, if confirmed. As a physician, I appreciate the goal behind the creation of the ACO model: better patient care. As a legislator, I would agree their successes have been modest to date, and there are some challenges they face as well. ACOs are a tool in the toolbox to help ensure high quality, low cost health care for beneficiaries. They are not a silver bullet to all of our country's delivery system challenges. If confirmed, I plan to work with the CMS Administrator to ensure that we learn from ACOs' successes and challenges to date as we chart the path forward.

For certain populations, bundled payments make a lot of sense. And they can often lead to both better health outcomes and reduced costs. But it is important we not get fixated on one of those two outcomes. That is, I support making certain that we deliver care in a cost-effective manner but we absolutely must not do things that harm the quality of care being provided to patients.

What we ought to do is allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve healthcare delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, we ought to remember we are not talking about science experiments in a lab or a computer simulation, but about experiments involving real patients' lives.

PAMA Implementation (Question from Senator Brown, Senator Menendez, Senator Casey, Senator Bennet, and Senator Wyden)

38. In 2014, Congress passed the Protecting Access to Medicare Act (PAMA), which included a provision to change the way labs are reimbursed under the Medicare program by moving away from the Clinical Laboratory Fee Schedule (CLFS) and toward a more market-based payment methodology.

We are concerned that CMS's regulations implementing this provision, finalized in June 2016, contain a reporting deadline that is difficult for the laboratory community to meet. In addition, many of our community-based and regional laboratory constituents serving the Medicare program have expressed significant concerns over requirements from the regulation that make reporting accurate data a concern, and requirements from the regulation that result in the exclusion of market data from the hospital outreach laboratory community. Lastly, we have concerns over CMS's definition of an "applicable lab" in the final regulation. We believe the current definition would result in very few labs having to report their data.

The Office of the Inspector General has also raised each of these issues – the timeline, accuracy, exclusion of hospital labs, and lack of required reporting – as potential flaws in the regulation in their September 2016 report, which addressed PAMA implementation. In fact, the OIG reported that only 5% of labs will be required to report payer data, excluding 95% of the market and thereby potentially skewing the market rates.

Question: In order to fulfill the goals of PAMA, it is critical that the market data collected and assessed by CMS represents the entire laboratory market, consistent with the statute, to ensure both equitable and successful implementation of the law. Understanding that this regulation is on a short time-line, given that CMS is set to finalize a new fee schedule in 2017 for implementation in 2018, what would you do to address the concerns listed above and ensure the new market-based payment methodology and payment processes for clinical laboratory tests are not unduly burdensome on community-based labs or potentially detrimental to patient access?

Answer: I appreciate your concerns regarding the implementation of PAMA. Certainly, we should strive for accuracy in this market data collection process. I look forward to following up with CMS staff and agree that community-based labs should not be unduly burdened and thus limiting patient access.

39. **Question: Will you commit to revisiting the definition of "applicable lab" to ensure equitable and successful implementation of the law, accurately reflecting the entire market?**

Answer: As you know, Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) added section 1834A to the Social Security Act (the Act), which requires revisions to the payment methodology for clinical diagnostic laboratory tests paid under Medicare, including reporting requirements for laboratories.

CMS finalized a low expenditure threshold to reduce the reporting burden on small laboratories. Under the final rule, CMS will generally exclude a laboratory from being an applicable laboratory, and thus from having its private payor data reported, if it is paid less than $12,500 under the CLFS during a data collection period. CMS expects that 95 percent of physician office laboratories and 55 percent of independent laboratories will not be required to report. Additionally, I understand CMS-imposed reporting requirements at the TIN level will be less administratively burdensome for the laboratory industry as compared to requiring data to be reported at the NPI level.

Medicaid and Family Planning Services

40. Two-thirds of births from unintended pregnancies in the United States are paid for by Medicaid or the Children's Health Insurance Program (CHIP). In 2010, these unintended pregnancies cost a total of $21 billion dollars, including $824 million in Ohio.

    We know that publicly funded family planning allows families to prevent unwanted pregnancies, and it is estimated that investing in family planning services would have saved public funding of unintended pregnancies by a total of $15 billion, including $607 million for Ohio. That's striking - almost 75 percent of the money that would otherwise be spent could be saved through more robust, fully funded family planning programs.

    Question: Do you acknowledge the effectiveness of investing in contraception and the need to continue the Medicaid state option to expand family planning services?

    Answer: If confirmed, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue approaches that fit the needs of their States. That being said, I would be hesitant to develop policy on the basis of financial cost of life.

41. **Question: How will ensure that family planning services, included access to preferred contraception methods, will remain available to all women, as you committed to do in today's hearing?**

    Answer: Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price. As we work towards a replacement for the ACA, I expect this will be one of the topics of discussion.

Federal Research

42. As Chairman of the House Budget Committee, you stated in your FY17 Budget Resolution that "the federal government has a role to play in supporting breakthrough research." As a medical doctor, you must understand the importance not only of funding research to find better cures for your patients, but also of funding the training of the next generation of doctors and researchers.

    Question: If confirmed, how do you pledge to protect and advocate for the government's critical federal research initiatives?

    Answer: As a physician, I am keenly aware of the progress that has been made and still to be made through important research initiatives that are fully or partially funded by the federal government. Implementing the recently-passed 21st Century Cures Act will be a priority in coming months and years, including leveraging the significantly increased funding for the NIH. NIH plays a leading role in so many public-private initiatives, and if confirmed, I look

forward to working with leaders at the NIH to advance their important mission and our Administration's efforts to promote innovation on behalf of the American people.

Syringe Exchange Programs

43. Like many communities in Ohio, your district in Georgia has been hit by a significant increase, a 4000 percent increase, in opioid-related deaths in the last five years. Simultaneously, we are also seeing an increase in hepatitis C infections and HIV infections among those who inject opioids and share syringes. One of the clearest examples of this connection is the HIV outbreak in Scott County, Indiana, the home state of Vice President Pence. In response to this crisis, then-Governor Pence declared a public health emergency and changed Indiana's policy to allow state dollars to support Syringe Exchange Programs or SEPs.

    The Centers for Disease Control and Prevention (CDC), Institute of Medicine, and many other scientific bodies have stated unequivocally that SEPs are highly effective in stopping the spread of HIV/AIDS and Hepatitis C. Cleveland has one of the longest standing SEPs, and as a result as seen a decrease in the rate of new HIV infections as a result of intravenous drug use. In response to progress like this, Congress partially lifted the restrictions related to the use of federal funds for SEPs in 2015. In fact, I note that your wife, who serves in the Georgia House of Representatives, has also worked to expand access to needle exchange programs.

    Question: In the past, you have voted against funding for needle exchange programs. Has your position changed?

    Answer: As I mentioned in the hearing, I recognize that the opioid epidemic is real and that substance abuse disorders are plaguing many Americans. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I have a broad and open mind and welcome proposals to our nation's mental health and substance-abuse related crises, particularly those solutions that are evidence-based. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

44. **Question: Do you support continued availability of federal funds for SEPs, based on local public health department determination of need? Why did you oppose it in the past?**

    Answer: The opioid epidemic is real and substance abuse disorders are a serious concern for communities across the country. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I recognize that we may not always agree on the solutions, but we have a duty to those who are suffering to work together to find the best answers to these severe problems. I welcome proposals to our nation's mental health and substance-abuse related crises, especially those that are well supported by evidence. Funding decisions ultimately rest with

the Congress, which holds the power over the purse. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

45. **Question: If confirmed as Secretary of HHS, how will you work with states to ensure they have the resources and support necessary to continue and open new SEPs?**

    Answer: It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. All levels of government need to engage and collaborate to identify effective solutions to these problems.

Antibiotic Resistance

The emergence of this superbug is extremely serious and illustrates both how quickly infectious pathogens can spread across the world and the need for international cooperation in detecting newly emerging health threats.

46. **Question: Do you agree that a dedicated effort to improving surveillance, data collection and research efforts is needed to prevent such rapid spread and evolution of antibiotic resistant bacteria?**

    Will you advise President Trump to continue President Obama's National Strategy for Combating Antibiotic-Resistant Bacteria (CARB initiative)?

    How will you ensure that the threat of antimicrobial resistance remains a high priority for HHS and its affiliates the National Institutes of Health (NIH), Food and Drug Administration (FDA), and CDC? In your opinion, how should the US work with other nations to combat these threats?

    Answer: I share your concern regarding the need to take seriously the public health threat posed by antibiotic resistance. I appreciate the important role HHS can play in combatting this public health threat, from identifying resistance and educating the American people about it, to helping to advance innovative, new therapies to treat emerging infections. If confirmed, I look forward to continuing to work in this area as part of HHS' public health mission.

Powdered Caffeine

47. In 2014, Logan Stiner – who was a senior at Keystone High School in LaGrange, Ohio – died just three days before his high school graduation from ingesting too much powdered caffeine. For the last several years, I have worked with Logan's family to raise awareness about the dangers of powdered caffeine and encourage the FDA to take meaningful action to limit access to powdered caffeine.

Right now, children and teenagers can buy this potentially deadly chemical in bulk from domestic and international retailers by simply going online and clicking a button – without their parents even knowing about it. Further, companies are trying to find creative new ways to reach consumers and to dodge states like Ohio that have already passed laws cracking down on this dangerous substance.

Question: The FDA advises consumers against using powdered caffeine and has called upon manufacturers to more accurately label these products. But these actions by the FDA do not go far enough. As Secretary of HHS, which has jurisdiction over FDA, how will you ensure that the Department's affiliates, particularly the FDA, are effectively educating and protecting consumers about the products available to them?

Answer: FDA plays a valuable role in providing the American public with timely information about FDA regulated products. I appreciate the importance of FDA informing individuals and families about whether or how to use these products. If confirmed, I will ensure that FDA is fulfilling its statutory responsibilities consistent with its public health mission.

Medicare Advantage Star Ratings Program (question for Senator Brown and Senator Portman)

48. As you know CMS uses a star rating system to display the quality of Medicare Advantage plans. High performing plans receive quality bonus payments. CMS also has an audit and appeals process by which to periodically evaluate plans on specific measurements.

    Over the past several years, there have been several circumstances we are aware of where plans are penalized in their star-ratings based on deficiencies found in an audit. We have heard from a plan based in our home state of Ohio that was penalized by the interaction between the audit and appeals policies and the star-ratings program.

    Question: If you are confirmed, can you commit to taking a deeper look at the interaction of these two policies and the potentially negative effect on plans, on beneficiaries, and on innovative care delivery?

    Answer: Yes. If confirmed, I would be pleased to work with your office and CMS to ensure that the Medicare Advantage stars system reflects quality and the Medicare Advantage sanctions system reflects program audit performance, as well as explore whether and how these policies can be made to work in concert rather than against each other.

Cancer Moonshot

49. During last year's State of the Union address, President Obama announced the Cancer Moonshot initiative, an ambitious project aimed at improving cancer prevention, diagnosis, and treatment at twice the rate of current progress of clinical cancer research. The 21st Century Cures Act re-committed to this critical initiative by through the inclusion of funding for the next 5 years of the program.

Academic and clinical centers in Ohio are playing important roles in the execution of this initiative, through partnerships like that that exists between The Ohio State University's Comprehensive Cancer Center and Columbus's Richard J. Solove Research Institute with Tampa's Moffitt Cancer Center to form the ORIEN partnership. This initiative is particularly focused on inclusion and retention of minorities in cancer-specific clinical trials, an important diversity metric to improve clinical care for all Americans.

Question: As Secretary of HHS, how will you work to facilitate collaborations between researchers and clinicians to improve cancer care under the goals outlined by the Cancer Moonshot?

Answer: If confirmed, we will make treating and helping to cure cancer a priority and there likely will be overlap with the Cancer Moonshot goals. Implementing the recently passed 21st Century Cures Act will be a priority in coming months and the Administration will accelerate efforts to promote innovation in many areas – including the prevention, diagnosis and treatment of cancer.

Tuberculosis

50. Globally, tuberculosis is now killing more people than HIV/AIDS, with a death toll of nearly 5,000 per day. In 2015, the US experienced the first national increase in TB cases since 1992, with 9557 total cases. And in 2013, CDC identified drug resistant TB as a serious public health threat.

    CDC provides critically important support to local health departments to address the TB epidemic, and it supports crucial TB research. CDC also provides crucial support to the global fight against drug resistant TB.

    Despite these sobering statistics and impressive work done by the CDC, funding for CDC's domestic TB program has remained stagnant since FY2005 at $135 million. As a result, the CDC has stated that are our national response to TB "has stalled."

    Question: If confirmed, will you implement the US National Action Plan for Combatting Multi-Drug Resistant Tuberculosis, and will you support increased federal funding for the US response to this deadly, airborne infectious disease?

    Better TB drugs and diagnostics are being developed, thanks to US ingenuity, and these new tools can help us stop this epidemic. What will you do, if confirmed as Secretary of HHS, to advance these drugs and diagnostics and provide support to the communities working to develop new treatments?

    Answer: As a physician, I recognize and share your concern regarding the public health threat posed by tuberculosis, particularly drug resistant tuberculosis. If confirmed, I look forward to working with CDC officials in their efforts to combat the spread of tuberculosis.

Low Income Heating Assistance Program (LIHEAP)

51. As you may know, the LIHEAP program plays a key role in helping low-income families stay warm in the winter and avoid dangerous heat in the summer. It is a program that is critical to nearly 450,000 households in Ohio that otherwise would be forced to choose between keeping warm or going hungry.

    Question: If confirmed, will you commit to maintaining the program as currently structured?

    Answer: If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible.

52. **Question: Nationwide, nearly 7 million of our nation's poorest and most vulnerable households rely on the program. Will you commit to maintaining and possibly even supporting an increase in the program's annual appropriation?**

    Answer: If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible. Should circumstances on the ground change, and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

Nuclear Medicine

53. Diagnostic nuclear medicine procedures help millions of Medicare beneficiaries detect life altering illnesses, such as heart disease and cancer, each year. The quick turnaround on nuclear testing, when used appropriately, helps improve the quality and efficiency of care by helping to reduce inappropriate or unnecessary procedures. Despite these positives, CMS continues to treat the diagnostic radiopharmaceutical drugs used in nuclear medicine procedures as supplies – not drugs – and, as a result, they are not appropriately reimbursed under this system.

    Question: Physician and industry groups have been working for years to try to address this issue. If confirmed, will you work with stakeholders to develop superior payment models to these drugs and nuclear medicine procedures are appropriately reimbursed?

    Answer: I share your concerns and look forward to working with you, if confirmed.

Therapy Caps (questions for Senator Cardin and Senator Brown)

54. As you know, the therapy cap exceptions process expires in less than a year—on December 31, 2017. We have all heard from constituents whose therapy needs exceeded the cap and their conditions have deteriorated, necessitating more expensive medical intervention.

Question: As Secretary of HHS how will you support the repeal of these arbitrary and discriminatory limits and maintain access to rehabilitation therapy that Medicare beneficiaries clearly need?

Answer: Rehabilitative therapy is a vital component of recovery for many patients. Arbitrary limits on its use are not a wise decision for patient-centered care. If confirmed as Secretary, I will look into this issue and seek to understand the competing objectives and issues motivating the current CMS policy. Part of the frustration with the current health care system is rules like this that do not make sense to many people. However, that is not surprising when one considers that Medicare Parts A, B, C, and D have each developed in silos and that even payment for particular types of services sometimes reflect silos within the silos. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed as Secretary, I would hope to break down these silos and encourage approaches based on a broader perspective.

55. **Question: Given the problems associated with monitoring the therapy cap, is CMS capable of achieving a timely uniform and defensible streamlined, responsive, and transparent process for manual medical review of Medicare records by Medicare administrative contractors?**

Answer: We will strive to do so. Any time there is manual review of anything in an organization with the scale of Medicare, it is a recipe for something to go wrong. If confirmed as Secretary, I would be pleased to work with you to confirm whether the staffing and other resources needed would be up to the challenge you describe.

Addiction Treatment

56. **Question: If confirmed as Secretary of HHS, how will you prioritize the prevention, treatment, and recovery from mental and substance use disorders in states like Ohio?**

As our country continues to explore potential reforms to our health care delivery systems, what will you do to prioritize access to behavioral health services?

Answer: Mental and substance abuse disorders continue to be a serious challenge felt in communities across the nation. I firmly believe, that it is absolutely vital that substance abuse disorders and other mental health problems are treated. If confirmed, I will work closely with you and the other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration fulfills its duty of treating those who are in addiction recovery while working to prevent people from becoming addicted in the first instance.

Pharmacists (question from Senator Bennet, Senator Casey, and Senator Brown)

57. *The Pharmacy and Medically Underserved Areas Enhancement Act* recognizes pharmacists as health care providers in underserved areas in order to expand access to care. In areas with a shortage of primary care providers, pharmacists may play a key role in helping patients manage their diseases to avoid Emergency Department visits and hospitalizations. These services are especially important for patients with multiple chronic conditions who may be taking several medications at a time.

Question: If confirmed, as HHS Secretary would you support this approach as a way to increase care in rural and underserved areas?

Answer: We ought to step back and say "What are we doing wrong?" as one of out every eight physicians no longer sees Medicare patients. Therefore, if confirmed as Secretary, I would be open to all options to address the impact of the ongoing physician shortage in rural areas. Paying pharmacists in underserved areas to engage in certain medical services could work well in those states where pharmacists have such licensure and a setting appropriate to the services, where primary care doctors continue to be involved in care, and where there is a patient and consumer demand for such services.

Questions for the Record from Senator Robert P. Casey, Jr.

Medicaid and CHIP

1. You have proposed eliminating the Patient Protection and Affordable Care Act, an action that would end the expansion of Medicaid to millions of people and would result in an addition $1.1 trillion being cut from state budgets. This action would throw millions of people into the realm of the uninsured, including hundreds of thousands with disabilities. They would no longer have access to such services and treatments as behavior health care, mental health treatment, and preventative services. The services provided by Medicaid expansion have greatly improved the quality of life for millions of citizens, particularly those with disabilities.

   Question: Do you propose those individuals return to being uninsured? Do you propose that their health care, including mental health treatments, be discontinued? Does your plan mean you support returning hundreds of thousands of people with disabilities into the category of the uninsured?

   Answer: Our goal is to ensure access to affordable, quality healthcare for all citizens.

2. If your plan is implemented, many people who will lose Medicaid coverage will be people with disabilities who depend on Medicaid for services that are unavailable through private insurance; services such as personal care services, respite care, or intensive mental health services. These health, personal care, and preventative services allow individuals to live in the neighborhoods of their choice, be independent, work, and participate in their communities. Many of these people, capable, able people, will be forced into institutions if they lose access to these crucial services. They will lose their independence and we will pay more tax dollars for their care.

   Question: How is this a good outcome for these people and for America?

   Answer: Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality healthcare for all citizens. This, of course, includes people with disabilities who depend on Medicaid. I note that community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in CMS' approach to Home and Community Based Services and the HCBS Settings Rule with a compliance date in March 2019, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances.

3. Federal flexibility in Medicaid has allowed Pennsylvania to take extra steps to ensure that children with extensive health care needs have access to Medicaid, in what's referred to as Family of One program. This program, in addition to the Medicaid expansion for parents, has improved the economic security of families in Pennsylvania. The state's budget relies on the federal share in order to support these Medicaid programs. However, the budget you authored in the House last year would have cut Medicaid funding by $1 trillion dollars, about one-third over a 10-year period.

   Question: Given that half of Medicaid enrollees in this country are children, how will you ensure that children and families aren't harmed by cuts in Medicaid funding through block grants?

   Answer: Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality healthcare for all citizens.

4. As a physician you know that Medicaid covers a broad range of services to address the diverse needs of the populations it serves. In addition to covering the services required by federal Medicaid law, many states elect to cover optional services such as prescription drugs, physical therapy, eyeglasses, and dental care. Coverage for Medicaid expansion adults contains the ACA's ten "essential health benefits," which include preventive services and expanded mental health and substance use treatment services. Medicaid provides comprehensive benefits for children, known as "EPSDT," that are considered a model of developmental pediatric coverage. EPSDT is especially important for children with disabilities because private insurance, which is designed for a generally healthy population, is often inadequate to their needs.

   Unlike commercial health insurance and Medicare, Medicaid also covers long-term care, including both nursing home care and many home and community-based long-term services and supports. More than half of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions. Given that both EPSDT for kids and long term services and supports are not generally covered in commercial health plans, I fail to see how people will not be worse off if the structure or financing of the Medicaid program is restructured in the ways that you and other Administration officials have suggested.

   Question: Can you guarantee that under a block grant, per capita cap and/or an HSA structure that all of these vital services will be covered for the millions of Americans who count on them?

   Answer: My work in the Congress has been to improve Medicaid and provide additional flexibility. If I have the privilege of being confirmed as Secretary I would look forward to the opportunity to work with states and Congress using the tools and authorities given by

Congress in legislation to ensure the highest number of people get access to the highest quality care.

5. Forty percent of Pennsylvanian children rely on Medicaid and CHIP, which serves our state's most vulnerable children: children living in or near poverty; infants, toddlers and preschoolers during key developmental years; children with special health care needs; and children who have been place in foster care due to neglect or abuse. Medicaid's comprehensive, pediatrician-recommended services under EPSDT – Early and Periodic Screening, Diagnostic and Treatment services – are critical for their health and to ensure that they hit key development milestones. In recent years, there is clear evidence of the long-term return on investments in Medicaid. Children enrolled in Medicaid are healthier as adults and more likely to graduate from high school, attend college, resulting in greater economic success.

   Question: Do you support the EPSDT benefit package for children which ensures that America's most vulnerable children receive the services they need to thrive? Are you willing to protect these benefits by not allowing states to waive this important benefit?

   Answer: Every state has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time to working with states to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. If I am confirmed, I will work with CMS as they take a look at waivers that are pending and appropriate for my input and will have to make a decision at that point.

6. Your 2016 budget proposal would have block granted Medicaid and would have eliminated many critical patient protections. With our current Medicaid structure, children have a right to the full array of services they need, from critical health screenings for cancer treatment to services for children with autism or mental health needs. For many children, this coverage can be the difference between life and death. Medicaid as currently structured also enables children with disabilities to live up to their potential, be successful in school, and have the opportunities to be full citizens.

   Question: Do you support the continuation of Medicaid's requirement to cover a comprehensive array of services for children through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program? Will you commit to ensuring that HHS will actively enforce the requirement to provide screenings, diagnosis, and treatment for children with disabilities or with potential disabilities?

   Answer: Our goal is to ensure every single American has access to the coverage they want for themselves or their children and dependents. I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not

be available to them for other reasons.

7. Many people with disabilities want to work and can do so with the services only available through Medicaid, to help them work. These services include supported employment for people with mental health disabilities or personal care attendants for those with intellectual or physical disabilities. Without these services, many people with disabilities will be unable to work.

   Question: How will you ensure that a person with a disability, mental health, intellectual, physical, sensory, or any other type of disability as defined by the Americans with Disabilities Act, has access to the services currently available through Medicaid?

   Answer: I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I commit to work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

8. As economies evolve, professions change and while new types of jobs emerge, certain types of jobs are reduced or eliminated and workers must make transitions. This happens to people across the workforce, but it happens almost twice as often to workers with disabilities.

   Question: Do you support taking away people's Medicaid coverage because they lose their jobs? How will you ensure that people with disabilities who become unemployed are able to retain Medicaid benefits?

   Answer: Medicaid is a vital safety-net program, and it is our goal to strengthen it. If confirmed, I look forward to faithfully executing laws to strengthen the Medicaid program that Congress passes and the President signs.

9. In 1999, in the *Olmstead* decision, the U.S. Supreme Court agreed that individuals with significant disabilities have the right, under the Americans with Disabilities Act, to access services in the community rather than only in an institutional setting. Since the *Olmstead* decision, the U.S. Department of Health and Human Services has employed its authority over Medicaid waivers to encourage states to expand home and community-based services and to shift away from overreliance on institutional care.

   Question: Will you continue this longstanding federal policy? If no, why not? If yes, what steps will you take?

   Answer: I support encouraging the use of home and community-based services if the

services are appropriate, the individual does not oppose the treatment, and the services can be reasonably accommodated.

10. Since the *Olmstead* decision, Congress has authorized several programs to incentivize states to meet their obligations under the *Olmstead* decision by increasing federal dollars for providing community-based services. These programs include the *Money Follows the Person* program, the *State Balancing Incentive Program*, the *Community First Choice State Plan* option, and the *Home and Community Based Services* option. These programs are implemented and managed through the Department of Health and Human Services.

    Question: Is it your view these programs should continue? Why or why not?

    Answer: I support ensuring that individuals are able to receive services in community-based settings.

11. You are a vocal proponent of passing federal laws to change Medicaid from a program that includes an open-ended federal financial commitment to fixed block-grant payments to the states.

    Question: Would this change end the federal oversight and incentive programs that have helped state systems transform into systems that allow individuals with significant disabilities to live in the community? How would you ensure that any changes in Medicaid would not move people with disabilities back into nursing homes and other institutional settings that are linked to significantly poorer quality of life, physical and mental health outcomes, and longevity?

    Answer: We are committed to supporting high-quality health care for all Americans, including individuals with disabilities. If confirmed, I look forward to working with you to achieve these goals.

12. In 2011, the Department of Health and Human Services promulgated a rule to ensure that Medicaid funds designated for services in home and community-based settings were not used to fund services in segregated, institutional settings. For example, the second floor of a building used to provide inpatient hospital care could not be considered a community-based setting. That rule has been championed by the disability community as critical to afford people with disabilities the chance to live independent and fulfilling lives in their own homes and communities.

    Question: Do you support the continuation of this rule? Do you commit to ensure that HHS assertively enforces it?

    Answer: Community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in the Home and Community Based Services

(HCBS) Settings rule you refer to, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances. States must come into compliance with the final rule by March 17, 2019, and I plan to work with states during this transition period to ensure continuity of services for Medicaid participants and minimize any disruptions to them and the service systems they currently rely on.

13. With an additional 16 million people gaining access to Medicaid since its expansion and a total of 75 million people covered by the program, Medicaid continues to be a critical, State-based health care program. In order to provide effective, high-quality care, States need dedicated funding for the full Medicare-eligible population as well as sufficient federal funding that reflects actual State costs and increases in health care costs.

    Question: As Secretary of HHS will you ensure that State-funding for health care is adequate and reflects the actual costs of caring for each State's Medicaid population?

    Answer: States are not just regulatory partners in the Medicaid program but also co-funders. As we look to provide them with more flexibility but also continue to provide federal funds, I agree it is important states meet their funding commitments and the federal government oversee and check that is the case.

14. Medicaid provides care to some of the nation's most vulnerable and complex populations. In order for States to continue to provide high-quality and effective care, adequate and sustainable funding is required.

    Question: As Secretary of HHS, will you work to prevent disruption and ensure adequate and sustainable funding for Medicaid?

    Answer: If confirmed, as Secretary I will work to prevent disruption and ensure adequate and sustainable funding for Medicaid. In fact, it is just this goal that is at the root of many improvements I have offered in my career.

15. During the hearing in the Finance Committee, you gave your commitment that you would "absolutely" support an extension of the Children's Health Insurance Program, and even expressed support for a longer extension of the program, beyond the typical 5-year authorization. Yet Gene Sperling wrote in the New York Times on Christmas Day that—

"Mr. Price's own proposal, which he presented as the chairman of the House budget committee, would cut Medicaid by about $1 trillion over the next decade. This is on top of the reduction that would result from the repeal of the Affordable Care Act, which both Mr. Trump and Republican leaders have championed. Together, full repeal and block granting would cut Medicaid and the Children's Health Insurance Program funding by about $2.1 trillion over the next 10 years — a 40 percent cut."[1]

Question: Do you deny that you have advocated for these changes to Medicaid and CHIP? You also said during the hearing that there were elements of the budget that you did not support. Which parts do you not support?

Answer: In the past, as a Member of Congress, I have advocated policies that would strengthen our health care programs so that they remain solvent for the sake of future generations.

16. During the hearing, you claimed we were looking at CHIP and Medicaid in a silo, instead of looking at the entire range of what the policy will be with respect to health insurance programs. We do not have anything to compare CHIP and Medicaid to, because this Administration cannot provide a clear plan that is a viable alternative to the Affordable Care Act, the CHIP program and Medicaid.

    Question: What will those policies be, and how will they provide better options for the children and individuals with disabilities who rely on CHIP and Medicaid?

    Answer: If confirmed, I look forward to working with you to ensure there are better options available.

17. In your answer to Senator Alexander's question at the HELP Committee hearing, you stated, "folks at the state level know their populations better than we [in Washington] ever could know them." The bipartisan, consensus-driven National Association of Medicaid Directors advocated for continuing the State Innovation Model (SIM) out of the Center for Medicare and Medicaid Innovation. The SIM has fueled 35 states (led by both Democrats and Republicans) to improve their local healthcare systems.

    Question: Given your desire to move decisions and innovation to the local level, as HHS secretary would you continue to support CMMI's state-level initiatives?
    http://medicaiddirectors.org/wp-content/uploads/2016/12/Key-Considerations-in-Affordable-Care-Act-Repeal-and-Replace-Initiatives.pdf

    Answer: CMMI is a program providing significant opportunity for testing new models for healthcare financing and delivery.

18. In reference to your reply to Senator Alexander, 16 states who have expanded Medicaid have Republican leadership. As of January 19, at least 5 Republican governors have publicly advocated to retain the federal-state Medicaid expansion partnership.

    Question: Given that several local leaders – including Republicans – favor retaining this program, what is your plan as HHS secretary to honor the wishes of state leadership, preserve this program, and avoid adverse consequences to states?
    http://www.politico.com/story/2017/01/gop-governors-republicans-obamacare-233576

    Answer: If confirmed, I look forward to working with Congress and Governors to ensure access to affordable, quality healthcare for all citizens.

19. **Question: In the past, you have stated support of expanding state waiver authority for the Medicaid program. Do you support efforts to evaluate the impact of these waivers in terms of access to care, quality of care, and costs of care?**

    Answer: It is my strong belief that we need to look at all possible outcomes of policy changes.

20. In 2015, your budget proposal would have repealed the Affordable Care Act, reduced Medicaid spending, and cut the Supplemental Nutrition Assistance Program – all told, up to $519 billion in cuts to needy families – yet your proposal would have increased defense spending higher than the administration requested, gathering criticism from other Republicans.

    Question: Are you only concerned with increased federal spending when it benefits families and children?

    Answer: In my time in Congress, I have been concerned with increased federal spending at all levels.

21. In your conversation with Senators Warren and Kaine during your appearance at the HELP committee, you cited access to care as your critique for the Medicaid program. You stated that Medicaid recipients have access to insurance, but they do not have access to the care they need. Yet the Government Accountability Office has stated that "Medicaid enrollees report access to care that is generally comparable to that of privately insured individuals and better than that of uninsured individuals." The report does cite more challenges with accessing specialty and dental care.

    Question: Do you agree with the GAO's assessment? If so, what strategies would you suggest to increase access to specialty and dental care for Medicaid recipients? If you don't agree with the GAO's assessment, please outline your plan to increase access to Medicaid-eligible Americans.

Answer: As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them. I know from personal experience the difficulties Medicaid patients face, and I receive letters about it all the time. My plan is to work with states to ensure they have the flexibility to make high quality care truly available.

22. It is true that Medicaid faces challenges, including low payment rates and barriers to interstate care which limit access and must be improved. Greater consistency of national data could significantly improve Medicaid's ability to serve children and other beneficiaries and drive quality improvement. Access to certain services, such as pediatric mental health services is a pressing concern.

    Question: What would you do as Secretary to drive improved outcomes in child health across states?

    Answer: Ensuring children have access to the health care they need is undoubtedly a top priority. If confirmed, I look forward to working with you to increase access to affordable health plans for families and children as well as taking the necessary steps to strengthen American families.

23. A major focus of congress and the administration has been on pursuing delivery system reforms that improve quality and reduce costs. The federal government over time has focused more on the needs of children in these reforms, but Medicaid for children still lags behind Medicare in supporting improvements in care.

    Question: What steps will you take to promote increased emphasis on reforms targeting the unique needs of children?

    Answer: Our goal is to make certain that every single American has access to the coverage they want for themselves and their children; and we must ensure that the individuals and children who lost coverage under the Affordable Care Act are able to access quality health care. If confirmed, I look forward to working with you on this effort.

24. To ensure kids continue to receive the critical care they need under Medicaid, any potential restructuring needs to consider children's unique health care needs and the impact of limiting our investments into their future and the nation's as a whole. Any reforms must ensure children's funding is stable, clearly defined, protects current services, and begins to remediate shortages in critical areas, such as mental and behavioral health services.

    Question: How will you ensure that Medicaid continues to deliver essential services tailored to the unique needs of children?

    Answer: If confirmed, I look forward to working with you to prioritize a nation of healthy children through increased access to affordable health plans for families and children, as well

as taking the necessary steps to strengthen American families.

Medicare

25. **Question: Do you support converting Medicare's successful Independence at Home (IAH) demonstration into a nationwide program? Do you support the inclusion of licensed mental health professionals on the primary teams for home-based team care?**

    Answer: If confirmed, I look forward to working with you on this issue. As a general matter, I believe we ought to allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve healthcare delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, it is important to remember many of these experiments involve real patients' lives.

26. **Question: The Medicare program requires that to receive telehealth services, a patient must be in a rural area and at an eligible originating site that currently does not include the patient's home. Do you support making a rural Medicare beneficiary's home as an eligible originating site for the use of telehealth services?**

    Answer: This is certainly something that we will take under consideration. Telehealth holds great promise, particularly for rural areas experiencing physician shortages and for patients with limited mobility. At the same time, allowing a beneficiary's home to qualify as an eligible originating site could create significant Program Integrity challenges. If confirmed, I will certainly direct CMS to take another look at this issue to ensure we are doing everything we can to maximize beneficiary access to care with appropriate safeguards against fraud.

27. **Question: Do you support the continuation of the new Merit-based Incentive Payment System as presented in the final rule on the Medicare Access and CHIP Reauthorization Act (MACRA)?**

    Answer: The recent CMS MACRA final rule approached the first year of the Quality Payment Program as a transition year, and took steps to address physician concerns regarding the burdens associated with program participation. I think significant challenges remain with respect to provider burden, and, if confirmed, I plan to direct the CMS Administrator to ensure that the program is structured to achieve its quality and budgetary goals, while ensuring that patients and the providers who care for them are at the center of our reform efforts.

28. In both the Medicare and Medicaid programs, we are witnessing increased participation in managed care plans. Yet in 1995, you objected to managed care as "the antithesis of our society[1]," citing that managed care threatens the doctor-patient relationship.

Question: As HHS secretary, what plans do you have to monitor the quality and effectiveness of Managed Care plans offered in Medicare (through Medicare Advantage) and Medicaid programs?

Answer: If confirmed, I will not pick winners and losers among different plans or methods of health care delivery. It is my intention to fairly and accurately monitor the quality and effectiveness of our entire care system, including managed care Medicare and Medicaid plans. The facts on the ground will determine our plan ahead.

29. In September 2011, DHHS released a new policy that implements the recommendations of the Memorandum on Hospital Visitation. The rules updated the Conditions of Participation (CoPs). The policy states that hospitals receiving Medicare of Medicaid payments should allow patients to designate visitors, regardless of sexual orientation, gender identity, or any other non-clinical factor. The HHS policy has enhanced hospital visitation rights of same-sex couples.

    Question: Assuming no legislative changes are made, as HHS secretary, will you continue to support and enforce these existing rules?

    Answer: It is essential that healthcare services be available to all people with the highest level of quality, affordability, and respect for their human dignity. As a physician, I believe that patients should be at the center of health care. This policy allows patients to designate their visitors, regardless of their identity, and I believe patients should have that authority.

30. In 2012, the Center for Medicare and Medicaid Innovation under Provision 5590 of the ACA funded the Medicare Graduate Nurse Education Demonstration project to address the primary care provider shortage, including the Hospital of the University of Pennsylvania. In Philadelphia alone, the project has produced 703 advanced practice nurses, the majority of whom have assumed primary care roles, a 78% increase since before the project launched.

    Question: As HHS secretary, do you plan to continue to support novel reimbursement models to address the nation's shortage of primary care providers? Would you consider expanding the successful Graduate Nurse Education demonstration project to other sites?

    Answer: I remain committed to ensuring that every American receives access to the care that he or she needs. Funding decisions, however, ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

31. There is universal agreement on the need to improve patient care and reduce costs. One way to do so is for the federal government to continue to promote the growth of health

information technology and electronic health records. One success in this space over the past several years has been the development and growth of the Direct Exchange network, which has allowed for millions of health care record exchanges over the past several years.

Question: Will you as HHS Secretary continue to support the expansion of Health IT and the use of networks such as Direct Exchange working with HHS-ONC to encourage and ensure the safe and interoperable exchange of medical records?

Answer: Electronic information sharing, as supported by interoperable health information technology (IT) systems, impacts overall care and the patient experience. Patients and providers often rely on the fast exchange of relevant, trustworthy information across health IT systems. Methods to improve flexibility and patient engagement, and clear the way for increased health IT interoperability should be examined as we work to improve healthcare delivery. I look forward to continued discussions with you regarding various means to improve the current health IT infrastructure.

Foster Care & Child Welfare

32. You have hardly any record on child welfare issues. The largest federal investment in child welfare is made through Title IV-E of the Social Security Act, which reimburses states for activities associated with foster care, and it is managed by the Department of Health and Human Services. While foster care is a critical, often life-saving intervention, we should be moving toward a system that not only supports children who can no longer remain safely with their families, but one that also helps stabilize struggling families so that they can keep their children when it is possible to do so safely. This focus on prevention is not only often in the best interest of children, but also in the best interest of state budgets, and states that have started shifting to a prevention-focused model have seen lower downstream costs associated with foster care, homelessness, health care and criminal justice. This is an especially critical issue right now, at a time when we are seeing foster care caseloads increasing as a result of the opioid epidemic.

Question: Do you agree that we must make investments in services aimed at helping vulnerable families?

Answer: Yes. The family is the foundation of society. It is critical that we build and sustain strong families by providing assistance when necessary for those struggling with addiction and mental health issues so that we prevent child neglect and violence against children.

33. The Department of Health and Human Services is the lead federal agency responsible for addressing child abuse and neglect, including prevention, foster care, reunification, and adoption when children cannot return home. As was discussed during your hearing, the new Administration is proposing to block grant Medicaid, which is the primary source of services to help families involved in the child welfare system. This system is experiencing additional strain as a result of the opioid epidemic, which has shattered many families across the nation.

Question: Have you considered the potential implications of block-granting Medicaid for families in the child welfare system?

Answer: I look forward to working with the Congress to ensure that all children have access to the coverage, regardless of family situation or personal circumstance.

34. **Question: Will you commit that, if confirmed as Secretary of Health and Human Services, you will take action to guarantee parents coverage of and access to mental health and substance use disorder services, to prevent child abuse and neglect and help reunify families?**

    Answer: Substance abuse disorder is a problem and the opioid epidemic is real. As I mentioned in the hearing, this is a rampant crisis that is harming families and communities across the nation. This harm includes the potential for abuse and neglect that you mention. I also said, and I firmly believe, that it is vital that substance abuse disorder and other mental health problems are treated. If confirmed I will work closely with you and other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of leading public health efforts to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities.

35. According to the Substance Abuse and Mental Health Administration, there are 21.6 million people that have a substance use disorder, with just 9.3 percent receiving treatment. According to research by Richard G. Frank, the Department of Health Care Policy at Harvard Medical School, and Sherry Glied, Dean of the Wagner School of Public Service at NYU, repeal of the Affordable Care Act will take $5.5 billion from the treatment of low-income individuals with mental and substance use disorders – 11 times the funding that Congress just provided through the 21st Century Cures Act.

    Question: Do you think such a reduction in both mental health and substance use treatment funds through a repeal will have an impact on the child welfare system and foster care numbers?

    Answer: Changes to the ACA should not be done in isolation. I remain committed to ensuring that every American receives access to the mental health and substance abuse care that he or she needs. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

36. The Affordable Care Act included a provision to allow children aging out of foster care to continue their health coverage through Medicaid up to age 26. Block-granting or capping Medicaid would essentially end this guarantee.

Question: Do you believe we should end this right to health *coverage* for former foster youth?

Answer: This would be a part of the new legislation that Congress will be voting on, so that decision is in Congress' hands. If confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

37. Currently, when families adopt children with special needs from foster care, those children are guaranteed Medicaid coverage through the age of 18. This is an important support for these children and their adoptive families.

Question: If confirmed as Secretary of Health and Human Services, what assurances can you give to these children and their adoptive parents that their health care needs will continue to be met?

Answer: The life and health of children with special needs is of great importance to me, as it has been when I practiced medicine and while I have been in Congress. I offer every assurance to children and their adoptive parents that I will do all I can, if confirmed as HHS Secretary, to ensure their needs continue to be met to the best of the Department's ability.

Ethics of Providing Health Care to People on Public Plans

38. You have been a member of a fringe physician group, the American Association of Physicians and Surgeons (AAPS), which espouses a number of very dangerous ideas, including perpetuating debunked myths about vaccines and claiming that it is "immoral" for doctors to provide care to people who rely on publicly-funded health plans such as Medicare, Medicaid and CHIP.

Question: Were you aware of these positions published by AAPS before joining the organization, and do you support those positions?

Answer: My initial membership in AAPS was based on their successful opposition to destructive health policy changes promoted in the early 1990's.

The Opioid Epidemic

39. According to the recent *Facing Addiction: Surgeon General's Report on Alcohol, Drug, and Health,* "Substance misuse and substance use disorders are estimated to cost society $442 billion each year in health care costs, lost productivity, and criminal justice costs." The National Survey on Drug Use and Health (NSDUH) reported in 2015 that 21.5 million people in the United States, over 8 percent of the population, had a substance use disorder.[1] The Center for Disease Control and Prevention reported over 52,000 drug overdose deaths in 2015.[1] Of the millions of people struggling with a substance use disorder, only about 10

percent receive substance use disorder treatment in a given year.[1]

Question: If confirmed as Secretary of Health and Human Services, what actions will you take to address the needs of Americans struggling with substance use disorders, especially those who are seeking treatment?

Answer: Substance abuse disorder is a problem and the opioid epidemic is real. As I mentioned in the hearing, this is a rampant crisis that is harming families and communities across the nation. This harm includes the potential for abuse and neglect that you mention. I also said, and I firmly believe, that it is absolutely vital that substance abuse disorder and other mental health problems are treated. If confirmed, I will work closely with you and other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of leading public health efforts to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities treating those who are in addiction recovery while working to prevent people from becoming addicted in the first instance, and explore other means available to HHS to assist those struggling with substance use disorders obtain treatment and to prevent addiction.

40. **Question: If confirmed as Secretary of Health and Human Services, will you commit to supporting, and as a Cabinet member advising the President to support, continued funding for opioid crisis grants, as administered by SAMHSA?**

Answer: I remain committed to ensuring that every American receives access to the mental health and substance abuse care that he or she needs. Funding decisions, however, ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

41. **Question: If confirmed as Secretary of Health and Human Services, will you commit to supporting, and as a Cabinet member advising the President to support, funding for the Substance Abuse Prevention and Treatment Block grant to preserve the critical safety net for Americans who require substance abuse treatment but who are uninsured?**

Answer: Access to mental health and substance abuse care is absolutely vital. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress which holds the power of the purse, and signed into law by the President.

42. **Question: If confirmed as Secretary of Health and Human Services, would you commit to supporting, and as a Cabinet member advising the President to support, funding requests for the National Institute of Mental Health and the National Institute on Drug Abuse to develop better treatments for substance use disorders?**

Answer: I remain committed to ensuring that all Americans maintain access to the mental health and substance abuse disorder treatments; however, funding decisions ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the HHS Secretary, I will implement the policies adopted by the Congress and signed into law by the President.

43. **Question: Integrated primary care and mental health care is one promising strategy to improving outcomes for Americans with substance use disorders. If confirmed as Secretary of Health and Human Services, will you support demonstration programs – which as Secretary you would have the ability to direct – to integrate primary and behavioral health care, through the Center for Medicare and Medicaid Innovation?**

    Answer: CMMI is a program providing significant opportunity for testing new models for healthcare financing and delivery. If confirmed, as HHS Secretary, I plan to work closely with CMS to ensure that CMMI -- after appropriate consultation with Congress, the States, healthcare stakeholders, and Innovation Center staff -- tests innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries.

44. A key challenge to effectively addressing the opioid epidemic in the United States is a shortage of qualified providers. The Affordable Care Act included a provision to establish a National Healthcare Workforce Commission, yet this Commission has never met.

    Question: If confirmed as Secretary of Health and Human Services, would you commit to supporting, and as a Cabinet member advising the President to support, a Congressional appropriation to convene this commission so we can understand the root cause of mental health provider shortages and develop evidence-based strategies to address them?

    Answer: As I mentioned in the hearing, it is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I look forward to working closely with you and the other members of Congress to ensure that the mental health profession is adequately, if not robustly, staffed for this and the future generations.

Coverage

45. On January 7, 2009, you penned a commentary in the *Wall Street Journal* that advocated for "access to coverage for all Americans and coverage that is truly owned by patients." Yet under the policy proposals you have authored, according to the Congressional Budget Office, "the number of people who are uninsured would increase by 18 million in the first new plan year." After repeal of Medicaid expansion and exchanges, 32 million Americans would be uninsured by 2026.

Question: How do you reconcile your position in 2009 with the analysis by the CBO in 2017?

Answer: I disagree with the conclusion drawn by CBO. If there are any changes to Medicaid, they should not be done in isolation.

46. You introduced the Medical Freedom Act of 2015, which would repeal the requirement that insurers offer dependent coverage until the age of 26. HHS estimates this provision has affected 2.3 million young adults**.**

Question: If confirmed, what is your plan to protect the health and well-being of young adults under the age of 26?

Answer: This would be a matter for Congress to determine through legislation. If confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

Children

47. Oftentimes, changes in the larger health care landscape take place, for example in the Medicare program, without a full examination of how these changes could potentially impact children, even inadvertently.

Question: As you look at health care changes at the national level as Secretary, how will you ensure that children's unique health care needs are taken into account?

Answer: I look forward to working with Congress to ensure that children will not be inadvertently impacted by potential changes to the health care system.

LIHEAP

48. The Low Income Home Energy Assistance Program (LIHEAP) provides short-term aid to vulnerable populations for heating or cooling assistance, crisis assistance or weatherization assistance. Without this support, many low-income participants would quickly fall behind on their bills and face shut-off of essential energy services. The program effectively utilizes a partnership between the federal government, state government and the private sector.

LIHEAP protects the most vulnerable in our society. According to the Campaign for Home Energy Assistance, in Pennsylvania in 2014, 35% of households receiving LIHEAP were elderly, 30% were disabled, and 18% had children under 5. You were a member of the Task Force on Poverty, Opportunity, and Upward Mobility that drafted the "A Better Way" plan that proposed to combine LIHEAP with 10 other social program grants to create a large block grant to states. Should such a plan come to pass, it would eliminate a dedicated fund for utility crisis assistance. In addition, your recent budget took across the board cuts from safety net programs and highlighted LIHEAP as one of several "duplicative anti-poverty

programs." While the Department of Energy also oversees an energy program (the Weatherization Assistance Program), this program provides grants to states to improve the weatherization and energy efficiency of low-income homes. Thus, serving a different, though just as important, service from LIHEAP.

a. **Question: Can you explain why you think LIHEAP is a duplicative anti-poverty program and which other programs in particular you think are providing the same services?**

   Answer: One of the main goals of the "A Better Way" plan was to match poverty-fighting programs with the needs of those on Federal Aid more effectively so that it is easier for them to get back on their feet. Using block grants, rather than dedicated grants, gives states and communities more freedom to use the funds where they are most necessary.

According to the National Energy Assistance Directors Association, states have been forced to reduce the number of households served by LIHEAP from 8 million to the current level of 6.7 million due to federal cuts to the program. This equates to 1.3 million eligible households nationwide that did not receive assistance.

LIHEAP is a critical safety net program to support the elderly and families as the country recovers from the economic recession. Families should not have to choose between heating their homes and putting food on the table. You have previously voted in the House of Representatives against increasing funding for LIHEAP.

b. **Question: Do you support increasing funding for LIHEAP? If not, why do you not support it?**

   Answer: If confirmed, I will administer LIHEAP as effectively and efficiently as possible. If once in office, and should circumstances on the ground change and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

c. **Question: Will you support maintaining the funding at the current level of $3.3 billion in the President's final recommendations for FY 2017 and proposed FY 2018 budget?**

   Answer: If confirmed, I will administer LIHEAP at the levels passed by Congress.

Tax Issues

49. **Do you think the President should disclose how much he stands to benefit from the repeal of the net investment income tax prior to signing the repeal of the Affordable**

Care Act into law?

Answer: This is a matter for the President.

50. **Question: With respect to subsidizing the cost of healthcare, please explain why an annually disbursed refundable tax credit is superior to a monthly insurance premium support credit.**

Answer: There are many healthcare scholars who have promoted the superiority of a credit versus a subsidy, as it may provide greater flexibility and options for patients.

Questions for the Record from Senator Debbie Stabenow

Continuous Coverage

1. Last week we held a forum and asked folks from around the county to share their stories and help inform the debate around repeal of the ACA. One of the women on the panel, Holly Jensen, was a small business owner insured with a plan she selected on the marketplace. Holly was living with undiagnosed depression, anxiety, and obsessive compulsive disorder that was getting worse by the day. It got to the point that she withdrew from her community, her work, and was really struggling. She was unable – understandably – to make her monthly premium payments. Luckily, because of Medicaid expansion, she was able to get the treatment she needed a few months later and is doing well today. Her small business is back up and running. However, she did not maintain coverage continuously, as your plan and many others require.

   Question: If the continuous coverage requirement were in place, Holly would re-enter the health insurance market and could be labeled with a pre-existing mental health condition, correct? How do you believe this problem is best addressed?

   Answer: I believe it is important that we as a nation make sure that every American has access to the kind of mental health care and health coverage that best meets their need. Additionally, it is imperative that all Americans have access to affordable coverage and that no one is priced out of the market due to a bad diagnosis. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

Maternity Coverage

2. As I mentioned today, prior to the ACA, the vast majority of plans on the individual market did not offer maternity coverage. You said today that women would likely opt not to purchase one of those plans if they were pregnant or planning to be. However, over the course of a health plan year, couples and families make many decisions about their health care future, sometimes including whether or not to have a child.

   Question: Given this fact, do you believe that all health plans should be required to cover maternity and newborn care?

   Answer: My hope is to move in a direction where insurers can offer products people want and give them the coverage they want. That, of course, can and would in many cases include maternity and newborn care. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans. And note that I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

Questions for the Record from Senator Maria Cantwell

Long Term Care

1. **Question: Do you share my view that patients should be able to age in their homes and communities instead of in nursing homes and other institutional/inpatient settings, so long as the patient chooses this option and it is clinically appropriate?**

   Answer: Our health care system should be able to accommodate the choices of patients, in consultation with their physicians, regarding the ideal setting for their care.

2. **Question: Do you agree with me that home-and-community based care is, in general, far less costly and more convenient for patients compared to institutional care in nursing homes?**

   Answer: Home and community based care is often less costly and more convenient as compared to institutional care in nursing homes. Our goal ought to be the right care in the right setting and the best care possible for Medicaid patients and all Americans. Too many Medicaid beneficiaries lack access to care.

3. **Question: Do you support incentives for states to transition or "rebalance" their Medicaid long-term care population from nursing homes to home and community-based care?**

   Answer: If confirmed, I will work to provide states the flexibility to pursue innovative approaches that fit the unique needs of their citizens.

4. **Question: Are you aware that, under the Affordable Care Act's Balancing Incentive Program (Section 10202), the state of Georgia was approved for $57 million to transition Medicaid beneficiaries from institutional long term services and supports (LTSS) settings to home-and community-based settings (HCBS), and, as a result of that investment, Georgia has been able to shift more than 10 percent of its long term care costs *from* high-cost nursing homes *to* low-cost home and community care, according to reports submitted to CMS and Georgia's program application?**

   Answer: Each state has different needs, and I believe CMS needs to work with states to ensure that, consistent with those needs, the Medicaid program provides the best possible coverage to their residents. It is not surprising that providing states with flexibility to tailor their Medicaid program leads to good results in general.

5. **Question: Do you support the Balancing Incentives Program in the Affordable Care Act?**

   Answer: I am committed to ensuring that Medicaid is available for eligible beneficiaries, and working with CMS to make sure that States are able to make the most use of available resources to serve their citizens with the highest quality care, if I am confirmed.

6. **Question: If you do support this program, or if you at least agree with its intent and goals, will you commit to working with me and my staff to expand federal incentives for states to "rebalance?"**

   Answer: Yes, I will look forward to working with you and your staff to explore proposals you have in mind and otherwise consider how best to provide states with flexibility to provide the highest quality care for Medicaid beneficiaries.

7. **Question: Do you believe that, if executed well, "rebalancing" programs such as Balancing Incentives can improve the care experience for patients and reduce state Medicaid costs?**

   Answer: The experience of our system is that while many different states may face the same problem, the approach that is most likely to succeed may depend on the particular state and other details specific to the circumstances.

Basic Health Program

8. The Basic Health Program (Section 1331 of the Affordable Care Act) is a state option that is providing health insurance and access to care to more than 750,000 working low-income individuals in New York and Minnesota. States that have taken advantage of this voluntary program are seeing lower costs for beneficiaries, higher enrollment, and net state budget savings, compared to not implementing the program. Through the Basic Health Program, states are price-makers, not price-takers.

   Question: Do you support the Basic Health Program as a way to empower states to negotiate a better deal on health insurance for their citizens?

   Answer: I support the efforts of states to innovate and find solutions for their citizens with respect to health care, in the area of insurance and otherwise.

9. **Question: Will your Department and CMS commit to funding and administering the Basic Health Program as required under current federal law?**

   Answer: If confirmed as Secretary of HHS, my role will be to administer the laws of the land as they originate from the Congress, including those relating to the Basic Health Program.

10. **Question: If Congress repeals the Affordable Care Act, will you commit to "not pulling the rug out" from the 750,000 low-income individuals who are benefiting from the Basic Health Program?**

    Answer: In working through the current situation and options for the future, I am committed to working towards solutions that provide meaningful access to care, not just insurance but actual care, for all, including – of course – these individuals.

11. **Question: In other words, will you use your administrative discretion as HHS secretary to not rescind funding for state Basic Health Programs, unless a rescission of that**

funding is explicitly required by a change to the statute?

Answer: If confirmed, I will follow the directions of Congress as contained in appropriations and other law regarding funding for health care programs.

Delivery System Reform

12. Washington state and the Pacific Northwest have led the way in pioneering nationally-recognized innovations in the delivery of health care – whether it is the Qliance Direct Primary Care medical home model, Group Health Cooperative's highly popular integrated coverage and care model, the Everett Clinic's price transparency initiatives, Boeing's Accountable Care Organizations, or dozens of others. Despite their innovations, health care providers in my state are paid nearly $2,000 less (per Medicare enrollee, per year) than the national average, based on CMS spending data compiled by the Kaiser Family Foundation. I would argue that, due to our current volume-based system, my constituents are paid less specifically because they are efficient and because they do a good job of keeping patients healthy.

    Question: Should the federal government reward such high-value health care providers, as long as we clearly define and agree upon metrics for what constitutes "high-value" care?

    Answer: I look forward to faithfully executing the laws Congress passes pertaining to health care provider reimbursement.

13. **Question: Does the current fee-for-service system encourage unnecessary health care spending? If so, can you please explain specifically how this system encourages unnecessary health care spending, including in which specialties of medicine?**

    Answer: The current system encourages unnecessary spending since too many of the decisions providers and patients make are determined by a distant federal bureaucracy and not based on the value of care that is provided to patients by their health care providers. If confirmed, I look forward to executing laws that reduce unnecessary health care spending.

14. **Question: As a physician, do you share my view that clinicians should focus more on keeping their patients healthy and less on paperwork?**

    Answer: Clinicians should focus more on keeping their patients healthy and less on paperwork. Unfortunately, it does not seem that is the current trend.

15. **Question: As a physician, do you share my view that the current fee-for-service system requires significant paperwork, including substantial time spent on coding and billing for each individual procedure or service rendered?**

    Answer: Clinicians should focus more on keeping their patients healthy and less on paperwork. Unfortunately, it does not seem that is the current trend.

16. **Question: You voted for the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) when it was considered on the House floor. Will you commit to working with Washington state health care providers to help them succeed in Medicare's new Quality Payment Program, as outlined in regulations by CMS, including Advanced Alternative Payment Models?**

    Answer: If confirmed, I commit to work closely with the CMS Administrator to make sure we implement MACRA in a way that is easy to understand, minimizes burden, and is fair to all affected providers.

17. **Question: Will you commit to fund and administer Medicare's Accountable Care Organizations, including the Medicare Shared Savings Program under Section 3022 of the Affordable Care Act, and will you commit to helping health care providers participate in these models, should they choose to do so? Will you commit to not taking any administrative action that would make it more difficult for Medicare beneficiaries or health care providers to participate in this voluntary program?**

    Answer: As a doctor, I appreciate the goal behind the creation of the ACO model: better patient care. As a legislator, I would agree their successes have been modest to date, and there are some challenges they face as well. ACOs are a tool in the toolbox to help ensure high quality, low cost health care for beneficiaries. They are not a silver bullet to all of our country's delivery system challenges. If confirmed, I plan to work with the CMS Administrator to ensure that we learn from ACOs' successes and challenges to date as we chart the path forward.

18. **Question: Will you commit to fully fund approved grants under the Center for Medicare and Medicaid Innovation (CMMI), and will you continue to fund and administer future payment initiatives under CMMI, consistent with the legislative intent of Congress in the Affordable Care Act?**

    Answer: If confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview.

19. **Question: Do you share my view that, given Congress's significant ongoing investment in the delivery of health care services, the federal government should fund research into health care quality? Will you commit to not taking administrative actions that would weaken the work of the Agency for Healthcare Research and Quality (AHRQ) within HHS?**

    Answer: I appreciate your concerns about health care quality. I also appreciate the fact that health care research may address patient safety, care management and methods to broaden access to healthcare services, among other issues. Healthcare studies also help to inform the discussion on ways to improve the quality of care and reduce costs. As you know, Congress will ultimately make the decision on whether to fund the Agency for Healthcare Research and Quality (AHRQ). Nonetheless, if confirmed, I look forward to working with you to more carefully examine AHRQ and determine how it may best drive positive patient-centered

solutions in healthcare. And if confirmed, I will work to ensure that HHS [appropriately] implements the statutes within its purview**.**

Health Care Legislation

20. **Question: I have authored bipartisan legislation (S. 2259 in the 114th Congress) to make it easier for rural health care providers to participate in the Medicare Shared Savings Program by allowing CMS to adopt a broader beneficiary assignment method than is provided under current law. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?**

    Answer: I look forward to working with you on this issue and sharing both feedback and assistance regarding the important policy issues in beneficiary assignment for the Medicare Shared Savings Program.

21. **Question: I have authored bipartisan legislation (S. 2373 in the 114th Congress) to require Medicare to cover an essential preventive product, compression therapy items, for beneficiaries who experience swelling from lymphedema. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?**

    Answer: As you know, CMS has a detailed process for making determinations regarding whether items and services are reasonable and necessary, if they can be considered eligible for Medicare coverage given other restrictions and prohibitions. From time to time, Congress sees it fit to make its own determination regarding specific items or services. If confirmed, I would be pleased to work with your team to provide information on the Medicare coverage process and potentially relevant considerations.

22. **Question: I have cosponsored bipartisan legislation (S. 3129) to preserve patient access to outpatient therapeutic services in Critical Access Hospitals and other rural hospitals. Similar legislation has been signed into law the last three years. Will you commit to working with me, my staff, and bill sponsors and cosponsors, on this issue?**

    Answer: If confirmed, I look forward to working with you and others in the Congress to see that critical access hospitals are best enabled to serve rural populations well.

23. **Question: Will you commit to providing me and my office responsive and accurate technical assistance on any future legislation I author or on which I seek assistance?**

    Answer: Federal agencies play a significant role in the legislative process, often including providing technical assistance. Such technical assistance can involve situations where the agency provides feedback but clarifies that the assistance does not reflect the views or policies of the agency or Administration. If confirmed, I will endeavor to work with you in this way as appropriate to ensure proposed legislation is consonant with the existing statutory and regulatory scheme

Washington State's Section 1115 Medicaid Waiver

24. On January 9, 2017, CMS approved Washington state's proposed Medicaid waiver ("Medicaid Transformation Project, No. 11-W-00304/0) under section 1115(a) of the Social Security Act. In securing agreement on this waiver, Washington state health officials and CMS spent countless hours over more than a year in good-faith negotiations. This approved waiver will help Washington state pursue a smarter and more innovative Medicaid program that reflects changes in health care delivery, technology, and the preferences of patients.

    Question: Will you commit to honor this approved waiver and not take any administrative action to rescind, weaken, or de-fund its components?

    Answer: It would be inappropriate at this point to comment on any specific waivers under consideration at CMS, but, if confirmed, I would work with the CMS Administrator to ensure that CMS uses its waiver authority to provide much needed flexibility to states to innovate within the Medicaid program,

Graduate Medical Education

25. **Question: The vast majority of Washington state counties are Health Professional Shortage Areas (HPSA's) according to HHS's HRSA. Do you agree with an established body of research illustrating that there are physician shortages in the United States, especially in primary care specialties and in rural communities? "**

    Answer: Access to care is a critical issue in many parts of the country, particularly for primary care in rural areas. The underlying physician shortage is sometimes worsened by government policies. If confirmed, I look forward to the opportunity to address these physician shortages, particularly as they relate to the Medicare and Medicaid programs.

26. **Question: Do you agree with previous Congressional intent that the federal government, through Medicare and other programs, has a strong role to play in graduate medical education (GME) policy and funding?**

    Answer: I have always been a strong supporter of efforts to support medical education. Congress has used the Medicare program from its inception to invest in future generations of doctors. Regardless of what we do in Washington, health care should always be about that one to one relationship of a patient to a doctor. That relationship of course requires a doctor. And so I am hopeful we can continue to find ways to remove disincentives to the practice of medicine and its rewards as well as support the profession in other ways.

27. **Question: Was your own surgery residency funded by Medicare?**

    Answer: Both my wife and I were residents at Emory University. I completed my residency in 1984. The Medicare program has paid for some portion of GME at participating hospitals since its inception in 1965.

Questions for the Record from Senator Mark Warner

Affordable Care Act

1. In December 2016, the Congressional Budget Office issued a report noting that it would define as insurance coverage only "a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals." The ACA established a set of services, known as Essential Health Benefits, that all insurance policies must include to make sure patients have appropriate health coverage.

Question: What would you advise the president define as "coverage" under a Republican ACA replacement plan?
In a repeal-and-replace scenario, will coverage obtained by individuals provide adequate financial protections against high medical costs?
Will you advocate for insurance policies under the Republican replacement plan that provide meaningful coverage so that insurers could not once again (1) charge higher premiums to women, people with pre-existing conditions, or others for reasons such as their profession or the industry in which they work; (2) drop or severely limit benefits such as maternity care and prescription drugs, which insurers must currently cover as "essential health benefits"; (3) reinstate annual and lifetime limits on coverage; or (4) charge deductibles, co-payments and co-insurance without limits?
Will you commit to safeguarding the consumer protections that the Affordable Care Act put in place?

Answer: This is a work in progress. If confirmed, I would appreciate your thoughts on how best to address these matters. It is important that any system have safeguards so that no one loses access to care due to a bad diagnosis. Additionally, credible coverage is important. Patients should be provided an array of options so they may select the one best for themselves and their family; and consumer protections are integral to any patient-centered system.

Drug Prices

2. The rise in prescription drug costs is squeezing American families as well as federal spending. We need to address this now. In your testimony to the HELP Committee last week, you agreed that we need to work in "a bipartisan way [to address the] root causes of drug prices, [and] to make sure that drug pricing is reasonable." But you refused to commit to specific policies. President Trump has said that we should allow Medicare to leverage its power as a payer, and negotiate drug prices with pharmaceutical companies.

Question: Do you agree with President Trump that Medicare should negotiate drug prices?

Answer: The issue of drug pricing and drug costs is one of great concern to all Americans. You have my commitment to work with you and others to make certain that Americans have access to the medications that they need. If confirmed, I look forward to focusing on how we can make health care more affordable, including prescription drugs. I share your concern regarding the importance of individuals and families being able to afford the prescription drugs they need.

Drug Price & Value

3. While we are moving towards paying for value in many areas of healthcare, in the drug space we have largely lagged behind. In the past year, we have seen some insurers and drug manufacturers pilot value-based arrangements that hold the manufacturer accountable for how their product performs in the real world on an agreed upon set of metrics. In 2015, I led a letter with my colleagues, Senators Kaine, Nelson, Shaheen, and Heitkamp, to the Centers for Medicare and Medicaid asking them to examine the potential of using value-based arrangements in Medicare and other public programs.

Question: Will you commit to working with me to identify potential regulatory policy barriers that should be reviewed in order to continue to move towards reimbursement for value rather than volume in the drug space?

Answer: If confirmed, I look forward to working with you and others to ensure that we are moving toward a health care system defined by high-quality, patient-focused care. I appreciate how reimbursement – and other regulatory policies impact physician behavior. If confirmed, I will ensure that HHS is a good steward of taxpayer dollars, with the goal of delivering the highest-quality care through its health care programs, including the Medicare program serving our nation's seniors.

Gabriella Miller/NIH

4. Gabriella Miller, a ten-year old girl from Leesburg, Virginia who suffered from pediatric brain cancer, became an extremely impressive activist on behalf of childhood cancer awareness before her untimely death. Her work led to the passage of the Gabriella Miller Kids First Act, and NIH has been moving forward to implement this law and expand pediatric research.

Question: Will you prioritize pediatric cancer research and implement the Gabriella Miller Kids First Research Act?

Answer: I am always inspired by the courage cancer patients bring to their fight against this devastating disease. This is particularly true when the patients are some of the youngest amongst us. It underscores why we must cure cancer. The NIH plays a pivotal role in supporting cutting-edge biomedical research across our country, including key efforts related to pediatric research, and I recognize that we must make progress on this front for the adults and children fighting cancer. If confirmed, I look forward to continuing HHS's important work to advance cancer research and bring forward innovative treatments as part of our shared goal of defeating cancer.

Cybersecurity / Internet of Things

5. The declining cost of digital storage and internet connectivity have made it possible to connect an unimaginable range of products and services to the Internet, with medical devices at the forefront of this trend. However, in many cases, manufacturers have brought insecure devices to market, with few incentives to design the products with security in mind, or to provide ongoing support to address vulnerabilities. For example, we have seen cases where an implantable device

lacked meaningful authentication methods, leaving it susceptible to unauthorized or malicious commands sent remotely.

Question: The FDA has taken important steps to addressing cybersecurity in the 'Internet of things.' This includes promulgating post-market guidance, working closely with cyber-security researchers, and engaging manufactures to promote development of more secure devices. Will you commit to continue and build on these efforts?

Answer: The safety of American citizens will always be a top priority of the HHS and ensuring the security of medical devices against the threat of hacking is critical to that end. If I am confirmed, the FDA will continue and improve upon its efforts to strengthen cybersecurity within the medical device industry as well as other related industries.

Ban on CDC Gun Research

6. Since 2013, Americans have died from incidents involving firearms and automobiles at almost identical rates. Over the last two decades, the federal government has spent $240 million a year on motor vehicle safety research, and motor vehicle deaths plummeted nearly 25 percent from 2004 to 2013 thanks to data supporting new policies. CDC has done virtually no research into gun-related injuries and deaths after an appropriations rider was added that prohibits the CDC from "participating in advocacy or promotion of gun control." Roughly 100,000 Americans injured or killed each year by guns, including over 2,000 in 2016 from accidental shootings alone. The original author of the appropriations rider, Rep. Jay Dickey (R-AR), has declared he regrets it and would like to see the CDC able to research violence and injury related to firearms. To make smart policy, it's necessary to have accurate information and data.

Question: If confirmed, would you direct CDC staff to interpret the appropriations rider in a reasonable way, so that CDC could in fact conduct unbiased research on the relation of firearms to public health?

Answer: The CDC performs an important role in helping to understand and communicate public health issues. If confirmed, I will work to faithfully ensure that the Department and its operating divisions fulfill their statutory responsibilities.

Rural Hospitals

7. Rural hospitals, serve older, sometimes more economically disadvantaged populations challenged by less access to primary, dental, and mental health care than their urban counterparts. Rural hospital leaders from across Virginia continue to share with me their concerns with efforts to repeal the Affordable Care Act. The ACA lowered the percentage of uninsured by 8 percentage points in rural counties, decreasing bad debt for providers in these areas, and providing them with some financial breathing room. Yet despite this progress, the Virginia Hospital Association estimates that 43% of rural hospitals in Virginia operate at a financial loss.

Question: Should there be supports included in an ACA replacement proposal to ensure these safety net providers can afford to keep their doors open to serve these vulnerable patients?

Answer: Our goal is to ensure access to affordable, quality healthcare for all citizens. This of course includes individuals who access care at rural or critical access hospitals. And so the best metric in the end is one that measures the extent of access to actual care, not just coverage, and the quality of that care as determined by patients working individually with their doctors. I look forward to working on this important issue with you, if confirmed.

8. Last week, CBO reported that in the first year after a repeal of the ACA marketplace subsidies would take effect, about half of the nation's population would live in an area that would have no insurer participating in the individual market, increasing to three-quarters of the population by 2026. You have emphasized "access" to coverage but the report suggests repeal in its effects will eliminate choice, competition, and access in rural communities, reversing much of the progress we've made to reduce the number of the uninsured, as well as reducing uncompensated care.

Question: What advice would you give President Trump on addressing the bad debt issues these rural hospitals would face post-repeal?

Answer: Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality healthcare for all citizens.

Home Infusion

9. While I supported the 21st Century Cures Act when it passed in December, I remain concerned about a provision which caused the misalignment of effective dates of two important policies. The Act included a provision Senator Isakson and I fought hard to include that would pay for services associated with allowing Part B to reimburse for Medicare patients to receive infusion drugs at their home starting in January 2021. However, a provision which was used to help pay-for such payment, a cut to the reimbursement rates for Part B Durable Medical Equipment (DME) home infusion drugs, had an effective date of January 2017. This leaves a four-year gap where home infusion services will not be adequately reimbursed.
While I work with my colleagues in Congress to fix this issue, I hope that the Centers for Medicare and Medicaid Services (CMS) will make every effort to ensure Medicare beneficiaries continue to have access to these lifesaving medications.

Question: Can you commit to report back on actions CMS and HHS can take to protect beneficiaries from losing access to life-saving care?

Answer: Yes. I look forward to working with you to find approaches to this issue that ensure access to the highest quality care.

Telehealth

10. I've worked with bipartisan members of the Finance Committee to expand the use of telehealth, especially in Medicare, and I was glad that at your hearing last week you called telehealth an "exciting innovation for rural and underserved areas."

Question: As Secretary, will your Department work with my staff and others to find ways to fully leverage HHS's existing authority to lower barriers for telehealth and remote patient monitoring in Medicare?

Answer: I share your interest in promoting telehealth. Telehealth can provide innovative means of making healthcare more flexible and patient-centric. Innovation within the telehealth space could help to expand access within rural and underserved areas. If confirmed, I look forward to continued discussions on telehealth, including on the best means to offer patients increased access, greater control and more choices that fit their medical needs.

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