S. HRG. 117–341

NOMINATIONS OF ANDREA JOAN PALM AND CHIQUITA BROOKS-LaSURE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

ON THE

NOMINATIONS OF

ANDREA JOAN PALM, TO BE DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND CHIQUITA BROOKS-LaSURE, TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

APRIL 15, 2021

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

48–327—PDF WASHINGTON : 2022

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THURSDAY, APRIL 15, 2021

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., via Webex, in the Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, Whitehouse, Hassan, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Thune, Cassidy, and Daines.

Also present: Democratic staff: Michael Evans, Deputy Staff Director and Chief Counsel; Ian Nicholson, Investigative and Nominations Advisor; and Joshua Sheinkman, Staff Director. Republican staff: Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order. Today, the committee meets to discuss two important health-care nominations. Chiquita Brooks-LaSure has been nominated to serve as Administrator for the Centers for Medicare and Medicaid Services, and Andrea Palm is nominated to serve as Deputy Secretary of the Department of Health and Human Services.

Ms. Brooks-LaSure has served at OMB, on the staff at Ways and Means, at the Department of Health and Human Services, and she has worked in the private sector. She helped craft policies bringing down costs for older people. She helped to develop and pass key portions of the Affordable Care Act. She helped implement the law, and she worked hard to make sure that middle-class families shopping for private health options would get a fair shake thanks to strong consumer protections.

Now, the Trump administration later undermined a lot of those protections, and that has created a host of new challenges for the committee and for the Biden administration.

Ms. Brooks-LaSure is also very well-versed in Medicaid policy, which is a hugely important part of this committee's responsibility. She has worked closely with the Federal Government, States, and private organizations to expand coverage.

Continuing on the theme of impeccable qualifications and experience, Ms. Palm is a proven health-care agency leader who knows what it takes to run HHS in a smooth way. She previously served as the Department's Chief of Staff and Senior Counselor to the Secretary during the Obama administration. Most recently, she served as Secretary-Designee of the Wisconsin Department of Health Services, a $12-billion agency. She has been the point person when it comes to COVID response in the State of Wisconsin. There she led efforts to expand insurance coverage, improve mental health care, and reduce hunger.

My bottom line: these are two individuals who are extraordinarily qualified for these essential positions and would be ready to go on Day 1 after they are confirmed by the Senate. There is a lot of work to be done at HHS; vaccinations are way up, but cases and deaths are still awfully high. Long, long way to go on the pandemic.

Now, the committee is also going to keep working on other important health challenges, which I and other members have discussed with our nominees. For example, I have said that every single time this committee talks about Federal health programs, we are going to be talking about updating the guarantee of Medicare. When I was coming up with the Gray Panthers, Medicare was an acute-care program. If you broke your ankle, it was Part A, or if you had a horrible case of the flu, then you went to the doctor or hospital for the broken ankle. Today, Medicare is cancer and diabetes and heart disease and strokes, and so many older Americans have two or more of these conditions.

So this committee led the bipartisan passage of the CHRONIC Care Act in 2017. The Trump administration slow-walked the implementation. So I am looking forward to working with both of our nominees to turn this situation around.

Second, the American Rescue Plan made a big down payment on mental health services. Senator Stabenow has worked tirelessly on this issue. And I was very pleased that now in the Medicaid program, for several years, we will have the CAHOOTS program, which is a fresh and exciting model so that mental health professionals and law enforcement professionals are teaming up to deal with the tragedies we see on our streets that so often involve mental health needs. I am very proud that Oregon has been a pioneer, and I gather, based on reports, that the Oregon program, their phones are ringing off the hook from around the country, from communities that want to copy what we have done.

A special priority for us on the Finance Committee is dealing with the issue of inequality in Federal health programs. We saw once again, during the pandemic, the results of health-care disparities up close. Blacks, Latinos and Native Americans have suffered and died from COVID–19 at much higher rates. Now, it is not just about COVID–19; it is about maternal health, because women today are more likely to die in childbirth than their mothers were a generation ago.

It is outrageous, I say to our nominees and colleagues, that in affluent white suburbs there are all kinds of health-care services of the most sophisticated nature, and in so many communities of color, it is like a health-care desert, and this committee is determined to change that.

Finally, we will be working closely with all of you on the issue of lowering prescription drug costs. A lot of Americans feel they are just getting mugged when they go to the pharmacy counter, and we have concrete ideas for doing something about it.

In addition to the CAHOOTS program, there will be other mental health issues. I am very troubled about the fact that the parity law, which is supposed to give mental health and physical health the same treatment, seems to be honored too often in the breach rather than in the observance. We will talk to you about that as well.

I want to thank both of you for being willing to do another stint in public service. We will hear from Senator Crapo, our ranking member, also from the Pacific Northwest, and then we have our colleagues here to introduce our nominees.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman.

When we held our hearing for Xavier Becerra to be Secretary of Health and Human Services, I noted the size and importance of the department he would lead.

In normal times, HHS and its agencies provide health-care service to nearly 150 million people, and those agencies affect the lives of many, many more on a daily basis. The COVID–19 pandemic has raised the salience of the Department. The Department's leadership, including the Deputy Secretary, will continue to play a key role in bringing us out of this public health emergency.

Similarly, Medicare and Medicaid are providing essential health care to patients who have suffered disproportionately from the COVID–19 pandemic. Looking to the future, the Secretary, the Deputy Secretary, and the CMS Administrator must carefully evaluate how best to use resources available to them to promote the health of our citizens. They must do so carefully, constructively, and creatively.

Two months ago, I outlined several issues in the health-care space where I intend to focus my efforts as ranking member, including fostering innovation to improve patient care and make our health-care system more efficient. The COVID–19 pandemic has threatened Americans' physical and economic health, but it has also reinforced the value of innovation and provided an opportunity to test changes that foster it.

HHS has used this authority under the public health emergency to waive numerous requirements to ensure Medicare and Medicaid beneficiaries and other patients receive care during the pandemic. Patients and providers have benefited from expanded access to telehealth and expedited approval of COVID–19 vaccines, diag-

nostics, and treatments. Going forward, Medicare and Medicaid patients must have the same access to those innovative items and services as those with commercial insurance.

We must carefully evaluate our response to the pandemic and implement appropriate reforms based on the lessons we have learned. HHS should partner with this committee in that effort.

However, media reports about certain health-care policies that may come before Congress, or be enacted through executive actions, are concerning to me. Some of these policies, such as including additional benefits under Medicare, could experience bipartisan support if considered through a transparent, cooperative, bipartisan process. Unfortunately, reconciliation does not afford Congress the opportunity to work together to evaluate these changes and make necessary reforms to protect the long-term financial viability of the program.

Other policies, such as expanding Obamacare's premium subsidy to everyone, regardless of income, would be incredibly expensive for taxpayers without taking appropriate steps to lower the cost of health insurance.

Creative, bipartisan ideas to lower the cost of insurance in the individual market have been raised by States and my colleagues in this committee. I welcome the opportunity to work together on these ideas, such as allowing States to use waivers to their full potential, diversifying benefit designs and incentivizing competition.

Finally, I am concerned about paying for some of these policies through changes in our drug pricing system that could stifle innovation. We can see the end of the COVID–19 pandemic approaching, thanks to groundbreaking vaccines developed by pharmaceutical manufacturers. In this crisis, industry responded to the Nation's call to arms, code-named Project Warp Speed, developing powerful and effective vaccines in record time.

This success was possible because of the private sector. I strongly agree with my colleagues that this innovation is only valuable if patients can afford it. We should establish an out-of-pocket spending cap and reform Medicare Part D with the market-based principles of competition and transparency in mind.

Ms. Palm and Ms. Brooks-LaSure, if you are confirmed, I look forward to working with you to improve our health-care system. I ask you to commit to careful assessments of the risks and considerations in every policy decision you make.

Political pressures possibly make unilateral actions seem attractive, but you should also consider how the market, individual choice, public policy, and incentives play vital roles in development and delivery of health care.

I look forward to hearing your testimony and your responses to questions.

These positions to which you have been nominated have substantial influence over policy. The members of this committee need to understand how you will implement the administration's agenda. And we expect your answers here and in response to the QFRs to be detailed and candid.

I look forward to the opportunity to visit with you today.

Thank you, Mr. Chairman.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo.

Our nominees have the good fortune of being introduced by two Senators with a long history of health-care advocacy, and we will start with Senator Baldwin, who will introduce Ms. Palm; then we will go with Senator Menendez, who will introduce Ms. Brooks-LaSure.

Senator Baldwin?

STATEMENT OF HON. TAMMY BALDWIN,
A U.S. SENATOR FROM WISCONSIN

Senator BALDWIN. Thank you, Chairman Wyden and Ranking Member Crapo, for holding this hearing, and I am honored to be here today to introduce Andrea Palm, President Biden's nominee for Deputy Secretary of Health and Human Services.

More than 2 years ago, Governor Tony Evers selected Andrea Palm to serve as Secretary of the Wisconsin Department of Health Services. I met with her very soon after that announcement and was immediately struck with her expert understanding of the health policy landscape, as well as her keen interest in building relationships with stakeholders from across our State.

Her prior experience, as a Senior Counselor to HHS Secretary Burwell and as a Senior Advisor on the White House Domestic Policy Council, provided her with strong qualifications to serve our State. With this foundation of experience, Andrea Palm delivered leadership to Wisconsin during the COVID–19 pandemic, and she built an effective response to the public health crisis we faced in our State, including her efforts to build a testing, contact tracing, and vaccination infrastructure in the State of Wisconsin.

Andrea's nomination as Wisconsin DHS Secretary, like other nominations from our Governor, was politicized from the beginning by the Republican-controlled Wisconsin State legislature. It is true they held up her nomination for months during an unprecedented global health crisis. It is also true that the State legislature refused to convene for more than 9 months, and instead sought to limit the power of the Governor and other public health leaders even as Wisconsin was experiencing one of the worst COVID–19 outbreaks in the country.

Despite these barriers, Andrea Palm led and put the people of Wisconsin ahead of State capital politics. In the face of consistent and constant political bickering and obstruction, Andrea Palm stayed the course and lived up to our State motto: "Forward." She made every possible effort to collaborate with stakeholders and trusted messengers throughout the State to protect Wisconsinites and provide them with the information needed to protect themselves and their families. And most importantly, Andrea provided leadership in Wisconsin that was always focused on science, public health, and the idea that we are all in this together.

Because of Andrea's leadership, Wisconsin has maintained one of the fastest vaccination rates in the country. She set us up for success in Wisconsin as a national leader in getting people vaccinated quickly, and I give her a tremendous amount of credit for where we today, because she helped put the partnerships in place that we

have used to get shots in people's arms and to protect public health.

She also worked to ensure robust data transparency since the very beginning of the pandemic, which continues to inform our vaccine roll-out and help us reach underserved communities. And in rural areas of Wisconsin, residents are getting vaccinated as quickly and as easily as residents in urban areas, a direct result of her focus on building relationships with stakeholders across our State.

Having Andrea back at HHS will be a tremendous benefit for the Department and all of our States, because she understands the urgent need to beat this pandemic and ensure the health and safety of all Americans.

Andrea, welcome back to the Senate, and thank you for your service to the State of Wisconsin. Your hard work has always enabled you to meet and overcome challenges, and I look forward to seeing you confirmed as Deputy Secretary of Health and Human Services.

The CHAIRMAN. Senior Baldwin, thank you, and you are always welcome in this committee.

Senator Menendez?

OPENING STATEMENT OF HON. ROBERT MENENDEZ, A U.S. SENATOR FROM NEW JERSEY

Senator MENENDEZ. Well, thank you, Mr. Chairman. And there are many reasons we want to finally beat this pandemic: the health and welfare of our families, our neighbors, and our fellow Americans. And because, after 16 years, I had finally worked my way down this dais close to Senator Stabenow, I am hoping that we can get to that point—that we can get there again.

Mr. Chairman, Ranking Member Crapo, and fellow members of the Senate Finance Committee, today I have the pleasure of introducing you to Ms. Chiquita Brooks-LaSure, President Biden's nominee to lead the Center for Medicare and Medicaid Services. And I must admit, I was thrilled to learn of Ms. Brooks-LaSure's nomination to serve as CMS Administrator.

A native of Willingboro, NJ, Ms. Brooks-LaSure graduated from Princeton University, earned a master's in public policy from Georgetown, and embarked on an impressive career in Federal health policy.

To say Ms. Brooks-LaSure understands the U.S. health-care system would be an understatement. Over the course of more than 2 decades, she has amassed a deep working knowledge of Federal health-care policy and the vital role that programs like Medicare, Medicaid, and the Affordable Care Act play in the lives of patients and consumers, especially those who are from low-income communities and communities of color.

CMS is sure to benefit from Ms. Brooks-LaSure's extensive experience, from her early days coordinating Medicaid policy in the Office of Management and Budget; to her work with the House Ways and Means Committee, passing signature legislation like the Affordable Care Act; to her service as Director of Coverage Policy at the Department of Health and Human Services; as well as deputy director for policy at the Center for Consumer Information and Insurance Oversight.

Most recently in the private sector, Ms. Brooks-LaSure worked at the firm of Manatt, Phelps, and Phillips, helping clients in the health-care space navigate regulatory issues often involving Medicaid and Medicare.

Simply put, her credentials are impeccable. And her commitment to building a more equitable and accessible health-care system is unshakable. If confirmed, Ms. Brooks-LaSure will be the first African-American woman ever to serve as CMS Administrator, and her historic nomination comes at a historic moment for our country.

The COVID–19 pandemic has exposed and aggravated the long-standing racial inequalities and inequities in our country, that even in good times, leave people of color more vulnerable to poor access, financial hardship, disease, and death. As we emerge from this crisis, I can think of no one better positioned or more committed to rooting out the disparities in our health-care system than today's nominee, Ms. Brooks-LaSure.

And I know my colleague from New Jersey, Senator Booker, asked as well to join in our enthusiasm for her historic nomination.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank our colleague, and our colleague has been heavily involved on health-care issues here today, so we are glad to hear his ringing support for the nominee.

I am also at this point going to introduce a letter of support, and a statement for the record.

Without objection, I will make these a part of today's hearing record.

[The letter and statement appear in the appendix beginning on p. 138.]

The CHAIRMAN. We will now have opening statements for Ms. Palm and Ms. Brooks-LaSure, and then we have some formalities we have to deal with. I thank our colleagues for being here.

Ms. Palm?

STATEMENT OF ANDREA JOAN PALM, NOMINATED TO BE DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. PALM. Thank you, Chairman Wyden, Ranking Member Crapo. Good to see you both this morning. I'm grateful for the opportunity to testify before you today as President Biden's nominee for Deputy Secretary of the United States Department of Health and Human Services.

I want to thank Senator Tammy Baldwin for the kind introduction and for her work on behalf of the people of Wisconsin. I'd also like to acknowledge and thank my husband Dan, who is here with me today. And thank you to the members of this committee for considering my nomination. I have enjoyed the opportunity to speak with many of you individually throughout this process.

I was born and raised in Star Lake, NY, a town of about 1,000 people. When you grow up in a small town, you understand from a young age that together is the only way to get things done. That sense of community was formative and is what led me to become a social worker. I spent my twenties as a caseworker, finding safe

homes for children in crisis and working with people in behavioral health crises.

These experiences shaped the rest of my career. It was the children and families I worked with during this time that made me want to change the system, and drew me to public service and to public policy. The memories of these kids are what still motivates me today.

I have spent my entire career focused on health and human services policy and lifting our most vulnerable communities, from my time in the Senate working on the HITECH Act to serving at HHS, where I played a key role in implementing the Affordable Care Act and negotiating bipartisan policies with Congress like the 21st Century Cures Act.

Most recently, I had the privilege of leading Wisconsin's Department of Health Services. I am proud of the work we were able to accomplish in Wisconsin. There, we found ways to make progress on a bipartisan basis, expanding access to telehealth services, our innovative children's health insurance program to tackle childhood lead poisoning, and improving delivery of the programs at the Department more broadly to better serve the people of Wisconsin.

And when the pandemic hit, we led with fact, science, and transparency to protect our communities. As every single State did, we faced challenges in Wisconsin. But we built a strong, State-wide response, leveraging government assets and the expertise of our private-sector partners to build a stable testing and contact tracing system, reaching our rural communities, and vaccinating Wisconsinites. And it is working. As Senator Baldwin noted, Wisconsin is among the top States in vaccinating our residents.

When I was previously at HHS, then-Secretary Burwell would joke that if there was an issue that was going to require bipartisan cooperation, the team should give it to me. She called my portfolio the "common ground agenda." And if I have the honor of being confirmed and returning to HHS, that is what I am bringing with me: a common ground agenda.

First, we must end the COVID pandemic. I know we can all agree that we have lost far too many Americans to this virus. President Biden put forward ambitious goals, and Congress has followed through, providing the resources to get the job done.

If confirmed, I look forward to implementing the American Rescue Plan, getting vaccines in arms, rebuilding the public health workforce, and securing the Nation's supply chain.

Second, we must expand access to high-quality, affordable health care. The American Rescue Plan took a major step in bringing down the cost of health care for working families, but we cannot stop there. We must strengthen our Medicare and Medicaid lifelines, reduce the cost of prescription drugs, better integrate mental health and substance use disorder treatment into our health-care system, and ensure our global leadership in research, development, and innovation.

And finally, we must prioritize human services. HHS has an important role to play, from caring for children to advancing the health and well-being of people with disabilities. We must not lose sight of those core missions.

HHS faces big challenges. And it is our responsibility to be tireless stewards of an agency that touches nearly every aspect of American life. To me, that is what public service is all about; making government work for the people it serves, and leaving the country better than we found it.

I am ready for the task, and eager to continue serving. Thank you again for considering my nomination.

The CHAIRMAN. Thank you very much, Ms. Palm. And we will have some questions here in a bit.

[The prepared statement of Ms. Palm appears in the appendix.]

The CHAIRMAN. Ms. Brooks-LaSure?

STATEMENT OF CHIQUITA BROOKS-LaSURE, NOMINATED TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. BROOKS-LASURE. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for considering my nomination to be the Administrator of the Centers for Medicare and Medicaid Services. It is humbling to be before you. And thank you to Senator Menendez for his kind introduction.

My career in public service started at the Office of Management and Budget, working on CMS's budget, Medicaid, and CHIP. But after 9/11, everything changed. It did for the victims of that terrible tragedy, their families, and for first responders. It also changed for many of you and for all of us in government service.

For me, my work shifted to finding coverage for dislocated workers in the wake of the attack. I worked closely with the Treasury Department and key members of the Bush administration to ensure that those impacted by this senseless attack had the health coverage they needed for such a vulnerable time in their lives.

It was inspiring to be part of a bipartisan effort to ensure that people who lost their jobs as a result of the attack and the economic aftermath were able to get the health care they needed. I took that philosophy and sense of mission with me to the Ways and Means Committee and then to HHS and CMS, where I led the development of policies that expanded coverage to more than 20 million Americans.

I have approached my work in the private sector with the same philosophy, working with States and stakeholders to expand coverage options, especially for those living in rural parts of the country and for traditionally marginalized communities.

Today, as we navigate this public health crisis and its aftermath, that philosophy guides me yet again, and if confirmed, that is the collaborative, common-sense, results-oriented philosophy I will take to CMS to address the complex challenges we face.

First, we must get the pandemic under control. COVID–19 has put unbearable pressure on front-line health-care workers, put vulnerable seniors and those with disabilities at great risk, and unmasked inequities that persist in our health-care system. My own home town, a predominantly black community where my parents still live, experienced higher rates of COVID infections and deaths compared to many of our surrounding communities.

I am committed to working with you and leaders across the government to ensure that CMS is supporting patients, their families, and providers, including communities of color, who have been hardest hit by this pandemic.

If confirmed, I will work to make CMS programs work together better and remain the pillars of our health-care system. This includes addressing Medicare solvency to protect Medicare for current and future beneficiaries. There is much we can do to strengthen these programs, to improve quality, lower cost, and expand access, including implementing the critical reforms in last December's appropriations bill and the American Rescue Plan.

If confirmed, I am also committed to working with you to expand access to innovative therapies, procedures, and models of care. We are living in an era of incredible change, as researchers find new ways to conquer disease and improve our quality of life. We must bear in mind, though, that innovation is only effective if patients can actually afford it. So I will work with you to reign in health-care costs, including for prescription drugs.

I realize we may not always agree on the best approaches to solve these challenges, but I pledge to work closely with all of you to ensure that our decisions are transparent, our team is accessible, and that CMS is listening to your views.

Before I close, I would be remiss if I did not acknowledge the outpouring of support I have received from women of color across this country. I am proud that, if I have the honor of being confirmed, I will be the first black woman to lead CMS. I would not be here without God and my family, my husband sitting behind me, my parents, my brother and sister, and the many strong, smart black women and men who came before me. Too often they were not given the opportunity to live up to their full God-given potential, but their selfless, often silent sacrifice paved the way for me and so many other women of color.

Today, I am proud that my daughter can see her mother nominated by the President of the United States to lead such a critical agency and know that she can be anything she wants to be.

Thank you for considering my nomination, and I look forward to answering your questions.

The CHAIRMAN. Thank you very much, Ms. Brooks-LaSure. And let the record show that Ms. Brooks-LaSure was also an intern to the Senate Finance Committee, and so we are very proud of that.

[The prepared statement of Ms. Brooks-LaSure appears in the appendix.]

The CHAIRMAN. Now, we have some obligatory questions we are going to ask, and I am just going to ask the question and have a response from each of you, if that would be all right.

First, is there anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Ms. Palm?

Ms. PALM. No.

The CHAIRMAN. Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. No.

The CHAIRMAN. Second, do you know of any reason, personal or otherwise, that would in any way prevent you from fully and hon-

orably discharging the responsibilities of the office to which you have been nominated?

Ms. Palm?

Ms. PALM. No.

The CHAIRMAN. Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. No.

The CHAIRMAN. Third, do you agree, without reservation, to respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress, if you are confirmed?

Ms. Palm?

Ms. PALM. Yes.

The CHAIRMAN. Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. Yes.

The CHAIRMAN. Finally, do you commit to provide a prompt response in writing to any questions addressed to you by any Senator of the committee?

Ms. Palm?

Ms. PALM. Yes.

The CHAIRMAN. Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. Yes.

The CHAIRMAN. Thank you both.

All right. Let us go on now to members' questions. We are going to do this in 5-minute rounds. And let me start with questions for you, Ms. Brooks-LaSure, and it really speaks to this judgment that I have had—and I have had two colleagues sitting on my sides who have shared it with me over the years—which is that I do not believe the Federal Government has a monopoly on good ideas. If the States can do better, they ought to be able to do it.

That is why I wrote section 1332 of the Affordable Care Act. It allows States to get a waiver to put in place fresh and creative strategies as long as they meet—this is critical—the essential consumer protection guard rails that are embedded in the Affordable Care Act.

So now, all over the country, there are States that would like to promote a public option, for example, to increase competition and hold down health-care costs, and there are some that are interested in aggregating Medicare and Medicaid dollars because they would like to move closer to a single-payer approach at the State level. Conversely, there are States with conservative ideas that would like to advance what they believe is the right course, and they believe that they can advance those conservative ideas while meeting consumer protection guard rails.

The reason I am asking you this question, Ms. Brooks-LaSure, is you had years of experience working closely with the States. And if confirmed—I believe, when you are confirmed—you will have authority to be involved in promulgating those kinds of guidance rules that will give a road map for the States on how to proceed.

How are you looking at your authority with respect to the States, and particularly ensuring that both progressive States and conservative States will say they have been treated fairly, showing that they have good ideas but never fudging on the essential consumer protection guidelines? How do you see your job in that regard?

Ms. BROOKS-LASURE. Thank you, Chairman Wyden, for the question and for your leadership in ensuring that States had an option

of applying for waivers to think about ways to improve upon the Affordable Care Act.

As you said, the Federal Government does not have a monopoly on good ideas and, in fact, some of the best ideas that are eventually enacted in Washington start at the State level, through waivers, through demonstrations. And there are so many States that are looking for the best ways to cover their populations; there is so much variety in our great country.

I see the role of the Federal Government in granting waivers as being a trusted partner with the States that have a great deal of responsibility across the Medicaid program, and in many States, their marketplaces and certainly their insurance markets. And I want States to understand what the rules are, to have consistent guidance, and to make sure they are meeting the standards that are set forth in the law.

Certainly I agree, and I think that States want to use the 1332 guidance to expand coverage and test different options in many ways. And if confirmed, CMS will certainly have an open door to States, to new ideas. And I really want to treat all the States with consistency and fairness, and then make sure they are meeting the guard rails.

The CHAIRMAN. One last question on this. Would you make it a priority to get the guidance out so that States with different philosophical viewpoints would know how to proceed?

Ms. BROOKS-LASURE. Absolutely. States need certainty and are on important schedules, annual budgets, and that is absolutely important.

The CHAIRMAN. We will have more conversations about the guidance, and I thank you for that.

Ms. Palm, let us talk about this whole question of health-care equity. I think you heard me in my opening statement say I think there are two health-care systems in America, plain and simple. The most affluent, and particularly those who live in suburbs, have a technology treasure trove in front of them in terms of how they can use telehealth and all kinds of services that are beneficial. Conversely, folks of modest means are just trying to figure out how to make their way through the maze of rules, even dealing with COVID services.

So my question to you is, if confirmed—and I believe you will be confirmed—how would you actually lead at the Department to root out the significant racial, ethnic, and geographical health disparities? Because I think that is what this is going to be all about. We are going to need leadership that has a real agenda to root out these systematic inequities. Tell us what yours would be.

Ms. PALM. Thank you, Chairman Wyden.

From my perspective, as Deputy Secretary, should I be confirmed, I think about this sort of on two levels. One is how we are working to ensure, at the programmatic and policy development level, equity and that an equity lens is baked into the development and implementation of our programs.

And then I lift up and think operationally about how we as a department are infusing, within our processes, the ways we need to do the work better, to bake equity in at the beginning so that we are not chasing it at the end. And so that, for me, is both pro-

grammatic and policy development, but then also operationally, we have the opportunity to really structurally change the way we do our work so that everybody is responsible for equity and making sure that the work that we do is equitable and that we are eliminating the systemic issues that have brought us to where we are today.

The CHAIRMAN. I think your point about individual accountability—my time is up—is hugely important, because at the end of the day, these issues have just gotten short shrift. I mean, the country has known about them, people say that you ought to do something about it, but it is really time for the kind of accountability that you just mentioned.

Senator Crapo?

Senator CRAPO. Thank you very much, Mr. Chairman. And I want to return in my questioning to the issue that the chairman dedicated his first question to: that of waivers.

I appreciated the chairman highlighting this issue and the focus that he brought to it. Waivers are an essential tool for States, allowing them to tailor insurance programs to fit the needs of their patients. Across the country, States continue to prioritize flexibility and the use of innovative, local solutions to expand coverage.

Unfortunately, this desire for flexibility has met Federal Government roadblocks, and this is especially true for Idaho. As I mentioned with both of you privately when we talked, Idaho has tried numerous creative approaches to expand and coordinate coverage between certain individual market and Medicaid populations. Medicaid 1115 waivers grant important flexibilities for States to improve benefits and to try new ideas in their Medicaid programs.

Obamacare's 1332 waivers allow States to implement policies that stabilize the market, lower insurance costs, and incent competition, provided—as Senator Wyden mentioned—that the guard rails are protected.

Yet when States try to merge the two waivers to coordinate and expand coverage, they are met with rejection and disappointment from the Federal Government far too often. This appears to be a statutory problem in many cases that prevents novel approaches to creating more seamless, harmonized insurance markets for patients. Without solving this issue, States must deal with population churn, inconsistent benefits, budget uncertainty, and the inability to advance changes that would improve care.

I realize you cannot change the statutes, but I do believe that as much flexibility as possible to allow States to use these creative options should be utilized. And I just first want to ask—and I think you have already basically said this to Senator Wyden—but if confirmed, would you work with me and others interested in improving the 1115 and 1332 waiver coordination through statutes? It is just a "yes" or "no" for each of you.

Ms. PALM. Yes.

Ms. BROOKS-LASURE. Yes.

Senator CRAPO. And I appreciate that.

And while this waiver work is underway, do you commit to incorporating State perspectives and expertise in CMS and HHS decision-making to ensure that local solutions to address coverage are included in your work?

Ms. BROOKS-LASURE. Yes.

Ms. PALM. Yes.

Senator CRAPO. Thank you.

And finally on this, I am deeply concerned by the current administration's approach to Medicaid waivers that were granted in the last administration. In other words, what will be the approach to waivers that have already been granted? While we should work to improve evaluations and processes for all waivers and demonstrations, the changes that have occurred this year on Medicaid waivers necessitate more immediate action.

Ms. Brooks-LaSure, do you believe revoking approved Medicaid waivers or portions of approved Medicaid waivers immediately following an election sends the wrong message to the States?

Ms. BROOKS-LASURE. Senator Crapo, thank you for raising the issue, and as I have mentioned, I do a lot of work with States and understand how much they want certainty from the Federal Government. That is something, if confirmed, I will really work on: to make sure that States understand decisions and, as you said, are part of the decision-making.

Senator CRAPO. All right; thank you.

And in the little bit of time I have left, I want to go back to you, Ms. Brooks-LaSure, on the Medicare Advantage issue.

I am a huge advocate for Medicare Advantage; I think it is one of the best-working pieces of Medicare, and we should do all we can to take advantage of it.

During the COVID–19 pandemic, CMS provided Medicare Advantage plans with additional flexibilities, such as expanding telehealth services, providing beneficiaries with devices to use for telehealth and remote patient monitoring, and reducing cost sharing and premiums, and we found some things that really worked.

Ms. BROOKS-LASURE. Yes.

Senator CRAPO. How would you work with stakeholders and Congress to continue these certain enhanced benefits and flexibilities? What I am talking about is, why do we have to stop this when the pandemic ends? Could you respond to that.

Ms. BROOKS-LASURE. Absolutely. I think that this pandemic has given us an opportunity to take the lessons across a variety of issues, and telehealth has been something that has been discussed for more than a decade, and now we have been able to see what value it brings. My brother is a psychologist, and he has been able to see more patients during a difficult time as a result of it.

I really want to work with all of you to look at what CMS's administrative authority is and what changes we may need congressionally to work on bringing the lessons that we have learned from COVID into our health-care system on a permanent basis.

Senator CRAPO. All right. Thank you very much.

My time has expired so, Ms. Palm, I will have to probably send you some questions for the record.

Ms. PALM. Thank you.

The CHAIRMAN. Colleagues, here is where we are: Senator Stabenow will go next in person, then we will have Senator Grassley on the web, and then we will have Senator Cantwell in person.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman, and welcome to Ms. Palm and to Ms. Brooks-LaSure. We are so lucky to have both of you willing to commit to public service at this very important time, and I am very impressed with your credentials, both of you—your experience and your credentials.

I care about every part of the health-care system, as you know. I have worked for years—it was actually health care that got me in to my own public service, and I think it is probably no surprise that I would like to start talking about behavioral health.

And so I would ask both of you—and I know, Ms. Palm, that you were at HHS when Senator Roy Blunt and I were able to pass the Excellence in Mental Health and Addiction Services Treatment Act, and that you were involved in the initial implementation and in establishing the quality standards. So I appreciate that very much, and I know you both have been involved in these issues.

But as you know, so many people are living with mental health issues and addiction issues right now, even more because of COVID. In January, 41 percent of American adults reported that they were struggling with anxiety and depression, and that is up from 11 percent before the pandemic. So we have serious, serious issues.

And more than one in four young people have reported suicidal thoughts. Meanwhile, communities are seeing more people overdose. Just yesterday the CDC reported that more than 87,000 Americans died of drug overdoses over a 12-month period that ended in September, the most deaths in a year since the opioid epidemic began in the 1990s. Serious alarm.

So long after the epidemic ends, these behavioral health issues will linger. And I have talked to both of you about—I believe strongly we need to treat health care above the neck the same as health care below the neck as part of the health-care system.

The good news is that, through Certified Community Behavioral Health Clinics that we now have in 41 States—and expanding now because of the American Rescue plan as well—we have a structure that allows clinics to truly meet the needs of the community. This has been a tremendous success, a model for the future, and I have to commend our chairman on the CAHOOTS program which this model also embraces as a partnership; so this is so, so important.

And now we have the opportunity to expand it nationwide so that every State has the opportunity to meet quality standards and provide comprehensive services. And now is really the time to do that.

So my question—I will start with Ms. Palm—is, could you talk about your experience working on behavioral health issues and how you will work with us to ensure high-quality comprehensive care, including through the CCBHC program?

Ms. PALM. Yes. Thank you for the question, and thank you for your leadership on this issue.

I think to your point, the bipartisan nature of the work that you and Senator Blunt have done on this, the bipartisan work that has happened around the opioid epidemic, really does afford us a critical opportunity at this moment to do additional work, to really, as I mentioned in my opening, integrate behavioral health into the health-care system. Your analogy of the neck-up and the neck-down

is exactly right, and I think it is really time that we think about mental health, substance abuse, the behavioral health issues as chronic conditions that need to be managed and treated the way other health-care conditions are; and that the health and wellness of people and putting them at the center of their health care means that we have to do that for behavioral health.

I have worked in behavioral health from direct service all the way to, as you mentioned, implementation of programs, and then most recently running them at the Department of Health Services in Wisconsin. And so I would look forward to the opportunity to work with you and others on this committee to really sort of turn the crank and take these next important steps in behavioral health.

Senator STABENOW. Thank you.

Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. I join my colleague in thanking you for your bipartisan work in this area, and highlighting just how much of an issue this is and has been. And then as you have stated, with COVID–19, it has been an incredibly difficult time for a host of people, including children, for a number of reasons.

I think that one of the important pieces is increasing providers, which is what the work of your clinic does by making more availability. We have seen telehealth help in this area. One of the things, if confirmed, I really want to focus on is helping CMS to coordinate better with the Department on these critical issues. States are doing some incredible things in their Medicaid programs and really coordinating that with the grants from SAMHSA to make sure that we are integrating behavioral health and substance abuse with physical health.

And finally I mention, of course, mental health parity is an important part of CMS's role of enforcing and ensuring that mental services are treated equally.

Senator STABENOW. Thank you.

Mr. Chairman, I know my time is up, but I have just one other thing I want to mention—no question, though—and that is school-based health clinics. We have authorized school-based health clinics to the end of the year, bipartisan legislation, but they are not yet funded. And yet we know that children and young adults have been hit particularly hard by the pandemic, not only anxiety and depression and other issues, but routine vaccination rates are down, and many children have missed primary care doctor's appointments and dental visits.

So Senator Capito and I are working together to secure funding for these clinics that have been authorized. We invite all of our colleagues to join us. I also want to work with each of you on these issues to make sure that school-based health centers are able to get the CHIP funding and Medicaid funding that will allow them again to be a permanent part of our health-care structure. This is very, very important for our children.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Stabenow.

Senator Cantwell?

Senator CANTWELL. I thought Senator Grassley was next.

The CHAIRMAN. Excuse me, he is not available right now.

Senator CANTWELL. Okay; thank you, Mr. Chairman. I just wanted to make sure we were not skipping ahead.

Thank you to the witnesses, and congratulations on your nominations. I certainly support moving you forward.

We have had a chance, at least our CMS nominee, Ms. Brooks-LaSure, to talk about the basic health plan I mentioned to you; how in New York approximately 800,000 people are enrolled in a plan that costs $500—$500—$500 annually for a family of four buying coverage. That saves $1,000 compared to the silver exchange plans, and it saves the State billions of dollars as well. So I want to make sure that it also saves us federally if more States implement this.

So I want to hear if both nominees are comfortable with States expanding this program, and if you would encourage them to do so. I do not mean to tell them to do so; I mean if they wanted to do so, would you be encouraging of that?

Can I get it for the record so we can hear you?

Ms. BROOKS-LASURE. Yes, Senator. Absolutely.

Senator CANTWELL. Thank you.

Also I want to make sure that the Department, Ms. Palm, would assist people in the implementation of that.

Ms. PALM. Absolutely.

Senator CANTWELL. Okay; great.

On Medicaid rebalancing, Senator Portman and I have been very big supporters. I just want to add that Senator Stabenow was also a big supporter of the basic health plan, and so I do not want to—she is very much appreciated, her efforts in getting that implemented; and we would like to continue to see the implementation.

On the Money Follows the Person program, Senator Portman and I and several others have been continuing to push that, giving over 8,000 individuals in long-term care facilities the ability to go back into their homes, saving Medicaid dollars. We feel like this has been—and rebalancing in general—a big cost savings.

So, Ms. Palm, will you work with States to implement the Money Follows the Person program to assure seniors and people with disabilities can avoid institutional living?

Ms. PALM. Absolutely.

Senator CANTWELL. Thank you.

And, Ms. Brooks-LaSure, do you support Federal incentives like those to help States move people from these high-cost institutional settings?

Ms. BROOKS-LASURE. Yes.

Senator CANTWELL. Okay; great.

My colleague has covered mental health.

So on my colleague from Idaho's conversation about telehealth, let's see if we can get a little more granular here.

What do you think—how do you characterize where the reimbursement rate should be? I have had great conversations with the University of Washington, Paul Ramsey, the CEO of that institution's health-care system. So in the Northwest we definitely are going to support more broadband access; we definitely see how this worked—you mentioned your brother. I can tell you personally there are lots of indications in my State of how successful this has

been. I think we got a real feel—a real feel for the medicine of the future.

So what do we do about the reimbursement rate? Is it 100 percent; is it the same? Is it slightly different for some reason? Where do you think we are? And I will start with you, Ms. Brooks-LaSure.

Ms. BROOKS-LASURE. Thank you for the question. I think it is an incredibly important issue, and one, as you said, that has been really critical in a number of States, in rural areas. And we need to think about how we continue to move this issue forward.

Reimbursement, I would say, is something I, if confirmed, would be happy to talk with you about and think through. There are certainly safeguards that we need, to make sure, from a program integrity perspective, that we know that services are being delivered, but it is one that I think that we will have to titrate but figure out.

Senator CANTWELL. Okay. For somebody who is intellectually smart on this subject, I consider that a little bit of a punt, but——

I think the issue—I am good with examining the savings, but I would say to people that this is just a new efficiency discovered in the information age, with COVID being the thing that prompted us here. But my guess is, we are going to see huge savings. So I would say you are at or close to the reimbursement rate that we are at today. It is almost something we want to incent, just like we have had pay follow the person, just like we have had these other things. Why? Because we are going to discover that there are probably savings here in the system overall.

So anyway, I do not know if you have any comments, Ms. Palm.

Ms. PALM. I would echo what my colleague said. I would also say we worked hard on a bipartisan bill in Wisconsin to bring telehealth into the Medicaid program, where we treated them the same for purposes of coverage and reimbursement, and we were really so grateful to put that statutory framework in place before the pandemic, and we used our flexibilities to really make sure we were ensuring access during the pandemic.

But I would certainly welcome an opportunity to continue working with you on this issue.

Senator CANTWELL. Thank you.

Well, Mr. Chairman and Senator Crapo, I think this is an incredibly important subject. We in the Commerce Committee with Senator Luján will be working on a broadband piece for the medicine delivery system. And one thing we really like is that we do have, even in rural communities, rural hospitals everywhere. So they are a system of delivery, and I think it would be foolish not to try to pair the broadband investment with the right reimbursement rate, because otherwise we would be making this investment and giving us access but not having the utilization because physicians or the system would continue to defer to see people in person.

So we have to get it right, and I so appreciate my colleagues. Thank you.

The CHAIRMAN. Senator Cantwell, as always, you are out in front on these issues. And Senator Crapo and I have been talking about a bipartisan effort in this telehealth area and as part of the critical reimbursement issue you mention, because this committee really shoehorned the telehealth efforts into the first CARES package.

I think it is going to be important to make sure that right now, as a result of the pandemic, we have removed some of the roadblocks for people to actually get to a telehealth provider. We are going to have to make those kinds of changes permanent, in addition to working on the critical reimbursement issue you have mentioned.

And I want to thank Senator Crapo, because he has indicated that telehealth could be one of the real bipartisan priorities for the committee.

Senator CANTWELL. Well, I am pretty sure that the three of us, whether it is the panhandle of Idaho or eastern Oregon or the Okanagan in my State, we see a very dispersed rural health-care delivery system where people have to drive hours. So I think this would be very helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for your leadership.

We are now on to Senator Cassidy on the web, and then Senator Bennet. Colleagues have a hectic morning, so we are trying in a bipartisan way to make sure that everybody gets a chance to be heard as soon as possible.

Senator Cassidy, I think you are out in cyberspace. So we would like to hear from you.

Senator CASSIDY. Yes, sir, Mr. Chairman.

Ms. Brooks-LaSure, thanks for reaching out. I enjoyed our conversation. As I told you, I was going to follow up on dual eligibles, not as a "got you" question but rather just kind of to explore it. We both know that we spend a lot of money in this country on duals, and we get miserable outcomes.

Now duals are a heterogeneous population, both in terms of who they are medically but also in terms of the method by which they are financed. But one thing you pointed out in our conversation is the difficulty in aligning the incentive for the State and the Federal Governments.

The ACA attempted to address the duals, and I do not think it worked. Can you give a little bit of a kind of "lessons learned" from the ACA's attempt to address the lack of alignment among duals?

Ms. BROOKS-LASURE. Senator Cassidy, I very much appreciated our conversation and enjoyed the opportunity to talk. As we talked about, dual eligibles are sometimes the most vulnerable in our society in terms of comorbidities, and often very expensive for both the Medicare and the Medicaid programs.

I think that, as we talked about, greater alignment is something that we are going to need to continue to work on. Some of that can be done by CMS administratively, with getting the programs——

Senator CASSIDY. But let me ask you particularly, what were the lessons learned from the ACA's effort? Because I think Minnesota may have been the only State in which their particular program worked. And so again I would like to build upon what we have learned. What have we learned?

Ms. BROOKS-LASURE. I would say—you know, when I look at the valuation, particularly around Minnesota, what I would say is, there still is a need to coordinate better on what we see in long-term care, and the nursing homes, and hospitalization. And some

of that is going to take legislation and really thinking about how do we treat people on the continuum?

So particularly in assisted living, PACE programs, I think there is more we can do to encourage that kind of coordination.

Senator CASSIDY. Ms. Palm, you have been kind of front and center on this in your jobs in Wisconsin. What thoughts do you have about the duals?

Ms. PALM. I appreciate the question, and your point about the different financing, and States and the feds working together for us, we were very focused on the continuum of long-term care services and providing the opportunity for patients, for seniors, people with disabilities, to choose care that best met their needs with the greatest amount of independence. And our ability to do that most effectively and efficiently would benefit from, as Ms. Brooks-LaSure mentioned, a greater alignment as you are sort of driving towards——

Senator CASSIDY. Let me stop you for a second. Let me just kind of stop you for a second. I think one of the things that happened in California was that there was an incredible amount of churn. People got assigned to a program, I think run by Medicaid, but with a Medicare—I may have this wrong, and you guys may know if I am correct. But this so-called patient choice ended up being churn where people were changing from program to program several times within a year, which of course destroyed continuity of care. And it begs the question as to whether or not the decision as to where to receive care was informed, or whether it was perhaps influenced by those who had other agendas.

Any thoughts upon this? Is there a way to address that? I will start with you, Ms. Palm.

Ms. PALM. Yes, I would say, Senator, we saw much more churn in our non-long-term care population in Wisconsin. I am not saying that what you are raising is not an issue——

Senator CASSIDY. I am saying among duals in general—duals in general.

Ms. PALM. Yes, I think that, sort of to your fundamental point, continuity of care, care coordination, making sure that we are putting patients at the center of the care they are receiving, and doing what we can to do that——

Senator CASSIDY. I guess I am not making my point, Ms. Palm. Everything you are saying is true. What I am trying to get at is, how do we address the churn?

Ms. PALM. Well, I think, Senator, from our perspective in Wisconsin, we wanted to make sure that the products that were available and the choices that seniors had were transparent on the front end, that they understood them, and that when they made their choice, they made a good choice for them so that there were not—there was not a need to change——

Senator CASSIDY. What was your rate of churn in Wisconsin? I am just curious; I do not know that answer.

Ms. PALM. Again, I am not sure I can remember off the top of my head in long-term care versus in the regular population, but I would be happy to get that information back to you, Senator.

Senator CASSIDY. Okay. I yield back. Thank you.

The CHAIRMAN. I thank my colleague.

Senator Menendez is next.

Senator MENENDEZ. Thank you, Mr. Chairman.

In March of last year, as COVID began to spread in States like mine, the shutdowns helped save lives. But at the same time, there were not systems in place to help individuals who rely on home and community-based services to continue to access care in such a situation.

The scarcity of protective equipment meant many providers were not able to access necessary gear. Fortunately, the American Rescue Plan provided an enhanced FMAP for these services.

My question to you is, will you commit to working with States to swiftly roll out information on how States can spend their increased FMAP for home and community-based services?

Ms. BROOKS-LASURE. Yes, sir.

Senator MENENDEZ. Okay.

COVID–19 has disproportionately impacted black and Latino communities. I am pleased to see this administration is committed to improving health equity. However, even as we have seen record-breaking developments of diagnostic treatments and vaccines for COVID–19, members of the most heavily impacted communities do not have equal access to clinical trials for these innovations.

And I believe we have to take active steps to remove these barriers. So, Ms. Brooks-LaSure, what role do you see for CMS to play in improving minority clinical trial participation?

Ms. BROOKS-LASURE. Thank you, Senator, for the question. This is such a crucial issue, and I am glad that Congress has made it so that Medicaid will be paying for covered services, to make sure that people can get into clinical trials. I think CMS can do more to integrate with NIH, as well as work with trusted partners.

One of the things that I think we have learned with the pandemic is how important it is to have the medical community, community organizations, really making sure that communities of color build trust in these types of programs.

Senator MENENDEZ. So will you commit to working with me on improving clinical trial diversity?

Ms. BROOKS-LASURE. Absolutely.

Senator MENENDEZ. Ms. Palm, the same question to you.

Ms. PALM. Yes, sir.

Senator MENENDEZ. Thank you.

Now throughout the pandemic, Americans have deferred health care. An October 2020 study in *JAMA* found that primary care visits declined 21 percent during the second quarter of 2020 as compared to the same time frames in 2018 and 2019.

In particular, I am deeply concerned that delays in cancer and other screenings will translate into an increase in advanced disease cases, and ultimately death as a result of millions of Americans avoiding routine preventative care over the past year. And once again, I feel these delays in care will disproportionately harm health-care outcomes for black and Latino communities, who already have less likely access to preventative care.

So, Ms. Brooks-LaSure, what steps can the Centers for Medicare and Medicaid Services take to raise awareness and encourage Americans to seek important and necessary preventative screenings that have been delayed as a result of the pandemic?

Ms. BROOKS-LASURE. You are so right to raise this issue, with so many people being concerned about going back to their providers. Because of the Affordable Care Act, preventative services across several of the programs are free. Because of its importance, CMS needs to continue to educate providers, beneficiaries, patients, and families, and again, working with stakeholders who are trusted partners, to encourage people to get preventative care.

Senator MENENDEZ. Ms. Palm, what additional steps can HHS take to help raise awareness of this looming issue?

Ms. PALM. It is a great question and really does lend itself to an opportunity across the Department, through our HRSA programs, to SAMHSA, to IHS, to the other avenues that we have, to reach the people that we serve with these messages encouraging folks to return for care, for the preventative treatment. So we should use all of our channels as well as our partners to reach people and encourage folks to return for care that they need.

Senator MENENDEZ. Finally, I worked on a bipartisan basis with members from both urban and rural areas at the end of the last Congress to secure 1,000 new Medicare-supported graduate medical education slots in the Consolidated Appropriations Act, the first increase in these positions in nearly 25 years.

Senator Boozman and Leader Schumer joined me in reintroducing the Resident Physician Shortage Reduction Act, which would build upon our bipartisan success by further increasing Federal support for GME.

Now that Congress has provided the slots, it will be up to the administration to determine their implementation, and it is important that they are distributed in a timely and efficient manner.

How would you plan to ensure smooth implementation of these critical new GME slots, and how do you envision working with Congress to address physician shortages?

Ms. BROOKS-LASURE. Thank you, Senator, for your work on this critical issue. And I very much understand that the congressional intent is for these slots to go particularly to underserved areas. I, as we have talked about, want to make sure that we have an open dialogue, one with public notice and comment where stakeholders can engage, and certainly an open door to hear your views.

Senator MENENDEZ. I will look forward to working with you on that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Menendez.

Senator Bennet has to preside on the floor, so proceed.

Senator BENNET. Thank you, Mr. Chairman, and I thank my colleagues for letting me jump in.

Ms. Palm and Ms. Brooks-LaSure, thank you for your willingness to serve and for all the work you have done to pass and implement reforms such as the Affordable Care Act, which dramatically improved coverage and affordability for health care in this country.

Despite the ACA's strides in coverage and affordability, many Coloradans and many Americans still face high costs and limited options. The American Rescue Plan expanded eligibility to the ACA premium tax credit. This capped how much Americans are paying for health plans on the exchange, which was, I think, very important, but still not enough.

Separately, Senator Kaine and I have previously introduced the Medicare-X Choice Act. It would work within the Medicare framework to establish a public option for individuals, families, and small businesses. It would also make the American Rescue Plan caps permanent.

As you know, President Biden ran on a public option as the answer to creating universal health care in this country, so I would ask that, if you are confirmed, that you—are both of you committed to working with me and others on the public option, and when it passes, implementing it to ensure that every single American has the health care that they need?

Ms. BROOKS-LASURE. Senator, thank you for your leadership on this issue, and for passing the American Rescue Plan which, as you have said, has significantly helped with affordability for middle-class families and given States options to expand the Medicaid program.

Of course we will work with you, and really want to advance the President's agenda; and as you said, he is supportive of a public option.

Senator BENNET. Ms. Palm?

Ms. PALM. I would concur with my colleague. I look forward to working with you.

Senator BENNET. I think this is something we should get done now. You mentioned it, Mr. Chairman, in your questions.

The American people, coming through this pandemic, understand how critical it is for us to have, for everybody to have, access to primary care. And this was litigated extensively during the campaign, in both the Democratic primary and the general election.

And so I hope the Biden administration will take us up on our offer to be helpful in fulfilling these commitments, and I look forward to working with the chairman as well.

Children with complex medical needs may not be able to receive highly specialized care that they need in their home State. This requires families and State Medicaid officials to go through the difficult process of finding out-of-State providers. Senator Grassley and I worked hard to pass the ACE Kids Act, which will be implemented in October of 2022 and would enable better care coordination for these kids to make sure that they get the best services, no matter where they live.

As a follow-up, last year we introduced the Accelerating Kids Access to Care Act. This bill would provide certainty for State Medicaid agencies to better determine who is responsible for paying and reduce regulatory burdens that can slow or prohibit access to care.

If confirmed, will you commit to a timely implementation of the ACE Kids Act and work with us on the Accelerating Kids Access to Care Act so we can make sure we are taking care of the Nation's most sick kids.

Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. Yes.

Senator BENNET. Thank you.

Ms. PALM. Yes. I would welcome the opportunity, Senator.

Senator BENNET. Thank you. I would welcome the opportunity too.

I guess I have time for one more question, so I am going to ask one. In December we passed the No Surprises Act, which will end the practice of surprise billing. I think this was a major step to protect patients who are often taken advantage of in their most vulnerable state. I have been working on that effort for years with Senators Cassidy and Hassan and others on the committee, and I am grateful it was signed into law.

Ms. Brooks-LaSure, in your written statement you mentioned you have the responsibility to implement the legislation when it goes into effect next year.

Can you highlight your thoughts on eliminating surprise billing and reiterate your commitment to implement the legislation over the next year, should you be confirmed?

Ms. BROOKS-LASURE. Thank you, Senator, and thank you to this committee, which has done so much work. Surprise billing has been an incredibly difficult issue for patients. Several States, before you passed legislation, had legislation on the books, but thank goodness that you all were able to reach a bipartisan agreement and really make sure the protections are in place.

If confirmed, I will absolutely work very hard to implement the regulations. I know we are on a very tight timeline, so I hope that I am so fortunate to be confirmed quickly to help with that effort.

Senator BENNET. Great. Thank you very much for your testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

Senator Carper is next.

Senator CARPER. Good morning. Great to see you both. I enjoyed talking with you by phone the other day. Thank you for joining us today, and congratulations on your nominations. We look forward to a swift confirmation, and the opportunity to work with you for any number of years.

I have the opportunity—we have a bunch of caucuses here in the U.S. Senate, as you may know. One of those is called the Senate Community Health Center Caucus, and the last time I checked, we have about 1,400 federally qualified community health centers across the country.

I think one of the smart things this administration has done early in its tenure is to make sure that people in neighborhoods across America can go to the federally qualified community health center and be vaccinated. I think that is a great move, and I think as we especially reach out to communities of color, folks who are frankly skeptical of taking the vaccine at all, it is a very wise move.

Ms. Palm, can you think of any other areas where community health centers could be better leveraged to address rural and ethnic health disparities and our pandemic recovery?

Ms. PALM. Thank you for those questions, Senator, and for your leadership on this issue.

I think from my experience in Wisconsin, I can tell you our partnership with our community health centers was critical, both before the pandemic and during the pandemic. Areas like behavioral health and their ability to be providers in that space, particularly in rural communities, were critical assets they brought to the table. We have a shortage of dentists in the State of Wisconsin, so dental

care in our community health centers is a critical access issue, again particularly in rural communities.

But to your point, their ability to reach underserved and ethnic minority communities is really critical for us to tackle some of these health disparity issues and deal with those head-on. So I think there are lots of opportunities for us to continue to work with those critical partners, and I look forward to doing that.

Senator CARPER. Good.

Ms. LaSure—do people call you "Ms. LaSure," or do they call you "Ms. Brooks-LaSure"?

Ms. BROOKS-LASURE. They call me Chiquita. [Laughing.]

Senator CARPER. I want so badly to ask you who you are named after, but I am not going to go there.

Ms. LaSure, as you know, we are not out of the woods yet on the pandemic. I think we are making some good progress; a lot still to be done, but it is incredibly important we keep the main thing the main thing—that is, to get as many people vaccinated as quickly as we can.

When I was Governor, I was very active with the National Governors Association and helped stand up something called the American Legacy Foundation, which was very actively involved in messaging on youth smoking, trying to convince young people not to use tobacco, and those who were using it to stop. Hugely successful initiative—hugely successful initiative.

And we are in a situation right now where we need a hugely successful messaging process on convincing people to accept vaccinations. And part of that is coming out of the private sector, part of it is coming out of like NYU, part of it is coming out of a coalition led by former Governors of, I think of Idaho and Massachusetts.

But I think it is a shared responsibility, and just talk to us, if you will, about that shared responsibility, the role the Department of Health and Human Services plays in getting that message out and convincing people to take the vaccine.

Ms. BROOKS-LASURE. It is so important. Thank you for your leadership in this area, making sure that people know and are aware that they can get vaccines, that they do not have to pay for them.

I, once again, want to talk about how what I really would like to see for CMS is to continue to partner with organizations. One of the things that I have heard over the last couple of months is how much people want to know, have their providers taken the vaccine? My brother-in-law, who sees many patients—he is a nephrologist—got vaccinated in part to make sure his patients knew he had taken the vaccine. And I think it is critical that we, if confirmed, at CMS are making sure that all the programs are encouraging this; that the plans are encouraging patients to know that this is an option.

Senator CARPER. One last quick question—and you can answer this for the record, but answer it a little bit while we are here—and that is, dealing with drugs, trying to rein in drug prices with the help of the Senate Finance Committee in Congress—and this would be for you, Ms. LaSure.

In your testimony, I think you mentioned that, although research is finding new ways to conquer disease and improve our quality of life—and this is a quote, I believe, from you—"we must bear in

mind, though, that innovation is only effective if patients can actually afford it," close quote.

That being said, in the interest of reining in health-care costs in collaboration with the committee and Congress, as CMS Administrator, how do you plan to use your role to address prescription drug costs? Please.

Ms. BROOKS-LASURE. Thank you. This committee has done so much bipartisan work on prescription drugs. We have to address this issue and make sure that we are lowering costs for these innovative medicines; and as Ranking Member Crapo said, we have seen so much innovation, and we want to make sure that people have it available.

I want to work with you all to make sure that we lower prescription drug costs—and am open to really working closely with you all on that.

Senator CARPER. Oh, you will have an opportunity in answering questions for the record to respond more fully, but I really was looking for, how do you plan to use your rulemaking authority to address prescription drug costs. I realize we are in this together, and we look forward to working towards that. Thank you.

The CHAIRMAN. Thank you, Senator Carper.

Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman. I want to take up where the Senator from Delaware just left off, because Senator Wyden and I have been working together for well over a year to lower prescription drug prices. Our bipartisan bill would cap out-of-pocket costs for seniors at $3,100. It slows the rate of growth of drug costs, saving the taxpayers $95 billion. Some believe we should let the government do more than what our bill would do. I am not sure that CBO is very interested in giving us much cost savings on that, if any. And some people in CBO would say if you did more, you would have to limit consumer choice and access to lifesaving drugs.

I believe that Congress must pass a bipartisan prescription drug bill if it is going to get done. I suppose if Democrats stuck together, then you could do it under reconciliation and that argument would not hold, but I hope that is not the course you go. And I think that a Wyden-Grassley bill could get 60 votes very easily.

The bill has meaningful provisions to lower drug prices. So is there any interest in the administration beyond what you told Senator Carper to working on enacting bipartisan prescription drug legislation?

Ms. BROOKS-LASURE. Senator Grassley, I so enjoyed our conversation and so appreciate your leadership with Chairman Wyden on this area and this issue, as I know you all care very deeply about making sure that we lower costs for patients and families. I have heard it from almost everyone—I think in all of my discussions—how much you all care about prescription drugs, and the administration certainly wants to work with Congress to come up with solutions for patients.

Senator GRASSLEY. And would I assume that that would be in a bipartisan effort?

Ms. BROOKS-LASURE. Absolutely, if people are interested—which I know you are—in lowering costs. The importance is in making sure we get this right.

Senator GRASSLEY. On rural health care, this is a big item for me and even for the chairman, because Oregon has a lot rural areas as well. I led a charge to create a newly voluntary Medicare payment program called Rural Emergency Hospitals. It is a new voluntary Medicare designation; I suppose something specifically for critical access hospitals. It would let hospitals maintain essential medical services in their communities, like 24/7 emergency care, outpatient care, ambulance services, and obviously a lot more. It will also let certain rural hospitals right-size their health-care infrastructure, letting them provide services that better align with the needs of their community.

Maybe this is something both of you should comment on; of course, you do not have to repeat the first person. But for both of you: can I have your commitment to implement the Rural Emergency Hospital program as quickly as possible—and I suppose as fairly as possible?

Ms. BROOKS-LASURE. Yes.

Ms. PALM. Yes.

Ms. BROOKS-LASURE. You have my commitment, Senator.

Senator GRASSLEY. Okay. Thank you, and I appreciated that discussion we had in my office.

This will probably have to be my last question. During the last 2 years as chairman of this committee, I worked to ensure that HHS's Office of National Security received access to intelligence community information. This included information involving threats to the Nation's health because of the virus. That office has gained access to some intelligence community elements, but more must be done.

On March 8th, I wrote a follow-up letter to HHS and the Director of National Intelligence, asking what they have done to incorporate Federal health agencies into the intelligence community. HHS has failed to respond, so I hope you can help us get a full response to that letter.

So let me go on to the second question. Do you agree that China is a significant and consistent bad actor when it comes to stealing U.S. taxpayer-funded intellectual property and academic research? If so, what will you do to protect American work products from the Communist Chinese Government's theft and espionage activities?

And if you do not feel that way, why.

Ms. PALM. Senator, I will take that one first.

If I am lucky to be confirmed as Deputy Secretary, I think this just is a place where my office—and where I—will certainly play a role in making sure, to your point, that HHS is read into intelligence that pertains to our health-care system, our data privacy, and some of the cyber issues that we hold at the Department.

To your point on intellectual property, I think it is a critical issue as we think about how we maintain and reassert our leadership in technology and innovation, and bringing our products to market in a way that continues to drive the health-care system forward. And I would look forward to the opportunity to work with you on both of those issues, should I be confirmed.

The CHAIRMAN. I thank my colleague.

Senator Cardin——

Senator CARPER. Mr. Chairman, can I be recognized for 30 seconds out of order, please?

The CHAIRMAN. Sure.

Senator CARPER. To our witnesses I will say, I have the privilege of working along with Sheldon Whitehouse and Ben Cardin and others on this committee, and on the Environment and Public Works Committee. We spent a lot of time in the last Congress trying to come to agreement on water infrastructure, clean drinking water, that sort of thing; wastewater or sanitation stuff.

We came close to getting it done; could not. We came back, and we were using that as a building block. To work on it, we are going to be on the floor next week with our water infrastructure legislation, all bipartisan.

And the other thing is, we spent a lot of time in the last Congress trying to pass service transportation reauthorization, a 5-year bill, and which we have part of the jurisdiction for; could not get it done. We are coming back and using what we did last year as a building block.

I just think you—and Mr. Chairman, you and Senator Grassley, before he leaves—you fellows did great work, absolutely great work. And we ought to be using your work as a building block in this Congress on drug pricing, and I would just urge us to do that. Thank you.

The CHAIRMAN. I thank my colleague for his kind words. I know we are going to talk about that topic this afternoon.

Our next member is Senator Cardin, who is on the web.

Senator CARDIN. Thank you, Mr. Chairman, and let me thank both of our nominees for their willingness to serve our country.

Ms. Palm, I would like to start with a question following up on Chairman Wyden's point in regards to minority health and health disparities. I heard your answer, but I would like to at least call attention to the fact that we have offices within the Department of Health and Human Services that are devoted to minority health and health disparities. We have the National Institute of Minority Health and Health Disparities, and we have been talking about a commitment to really deal with the systemic challenges that we have in health care in America. It came out very clearly in COVID–19.

So I would ask if you are committed to using every resource we have, including the direct involvement by your office in the minority health offices to develop a strategy to make fundamental changes in our health-care system to help the underserved communities. Your response?

Ms. PALM. Sir, I appreciate your raising this, and for your leadership in the creation of those components at HHS. And certainly, we need to integrate them in our work, because I think the challenge is that we cannot allow those offices to be seen as the only places where that work happens.

And so it is critical that they exist, but it is critical that we integrate them in a way that helps us all be accountable for the equity work that we need to do.

Senator CARDIN. I thank you for that. I agree completely with that. These offices are critically important, but they need to be integrated into the overall strategy on our health-care policies.

I also was listening to my colleagues talk about telehealth, and I certainly concur in their view that telehealth offers tremendous potential for access to care, particularly in underserved communities. We have talked about it being available for those who understand how to use telehealth and have the access to it, but we also need to make a priority of dealing with the underserved community, with access to telehealth as well as structural changes within the reimbursement structure, to allow the development of telehealth in so many different fields.

We did that during COVID–19; we made some of those provisions permanent. We need to expand that, and I look forward to working with you and the other members of the committee as we expand telehealth.

Ms. Brooks-LaSure, I want to ask you—we had a chance to talk about the fact that the Department has started the process of filling the position of Chief Dental Officer. I just really want to underscore the importance of getting that position filled as soon as possible. It was vacant during the Trump administration, but it demonstrates a priority within CMS to deal with the issues of oral health.

So I hope that you will pay attention to getting that position filled when you are confirmed.

Ms. BROOKS-LASURE. Absolutely, Senator Cardin. You have my commitment on that, and I want to thank you for your leadership in keeping the memory alive of the young boy who died because of lack of dental coverage. It will be a priority of mine to make sure that the Medicaid and CHIP programs have a dental officer who is informing the work.

Senator CARDIN. Thank you. Deamonte Driver was that individual who died in my State in 2007, and it did change our understanding of the importance of oral health care, as policy-makers, and I am pleased that we took action both in the CHIP program and in the Affordable Care Act program.

My last point deals with the issue of prescription drugs, and one area which is totally unacceptable. In the wealthiest Nation in the world, we have relatively inexpensive drugs that are in drug shortage because drug manufacturers do not make the same amount of profit on those drugs as they do on others. In some cases, they are single-source manufactured drugs.

And I would ask that there be a commitment by both of our nominees to make sure that that circumstance does not exist in this country, that we do not have drug shortages of inexpensive drugs that are not being made available solely because of the lack-of-profit motive to the private sector.

And if I could have a commitment to work with us to deal with those drug shortages—let me start first, if I might, with Ms. Palm.

Ms. PALM. Yes. It is a critical issue, Senator. You have my commitment.

Senator CARDIN. Thank you.

Ms. Brooks-LaSure?

Ms. BROOKS-LASURE. And mine as well.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cardin.

The next member—and I believe he is on the web—would be Senator Thune. Is Senator Thune out there in cyberspace?

[No response.]

The CHAIRMAN. All right. Then Senator Brown is next, also on the web.

Senator BROWN. Thank you, Mr. Chairman. I just want to thank Senator Cardin for always raising oral health and dental health, and that is so, so important, both for Medicare, obviously, and Medicaid, but especially Medicaid and the work that he has done.

Thank you for that.

Thanks to both of the witnesses for their willingness to serve and for their commitment to reducing health disparities, prioritizing policies to address social determinants of health. The history of institutional racism within our health-care system continues to affect health outcomes for communities of color.

I chair the Banking, Housing, and Urban Affairs Committee. We just had a hearing yesterday on, from the Black Codes to Jim Crow to redlining, to the Trump administration locking in discriminatory housing practices, what that has meant to health care and to wealth accumulation and inequality and all that. So what you are doing in health care is so very important.

Ms. Brooks-LaSure, a question first for you. Medicaid and Medicare are not just payers; they are powerful tools to advance healthcare quality and access to improve population health outcomes and act as economic drivers for workers in their communities.

Will you commit to working with my staff and others on this committee to create and strengthen initiatives across CMS to address social determinants of health and reduce health disparities?

Ms. BROOKS-LASURE. Absolutely, Senator. And thank you for your leadership in this role, this critical issue. And it is certainly a priority of mine.

Senator BROWN. Thank you. We knew that; we wanted to hear you say it again. So thank you.

One of the topics I raised with Secretary Becerra at his confirmation hearing was the growing gulf between traditional Medicare and Medicare Advantage. In recent years, both Congress and HHS have expanded the scope of benefits available to those enrolled in Medicare Advantage plans without doing so for those individuals who choose to remain in traditional Medicare. You have seen what has happened over 20 years of essentially privatization efforts.

This question is for you both. If confirmed, will you work with me to ensure all Medicare beneficiaries, whether they are in traditional Medicare or enrolled in Medicare Advantage plans, have access to the same benefits and out-of-pocket protections?

Ms. BROOKS-LASURE. Yes, Senator.

Ms. PALM. Yes, sir.

Senator BROWN. Thank you.

One final issue for Ms. Palm. The Children's Hospitals Graduate Medical Education (CHGME) program is of critical importance to Ohio's six freestanding children's hospitals. Senator Casey and I have for years worked together on a number of children's issues

where he has led, and especially with children's hospitals. Our States have some of the best children's hospitals in the country.

Ms. Palm, will you commit to working with Senator Casey and me and the future head of HRSA to make sure that the Children's Hospitals Graduate Medical Education program and training for the next generation of pediatricians remains a priority for this administration?

Ms. PALM. I would be happy to, Senator.

Senator BROWN. Thank you. It has never been easy with any administration, by budget time and other things, for GME, for Children's Hospitals GME. So we are counting on you to be a little bit different and a lot better than some of your predecessors, Ms. Palm. Thank you so much.

Mr. Chairman, I yield back a minute and 40 seconds.

The CHAIRMAN. Thank you, Senator Brown. Always leading, always leading.

Senator Thune, are you available now?

[No response.]

The CHAIRMAN. All right. Then we have Senator Casey and Senator Whitehouse next.

Senator Casey?

Senator CASEY. Mr. Chairman, yes, thank you very much. And thanks for your leadership on a number of the issues we are going to raise with our two nominees. Ms. Brooks-LaSure and Ms. Palm, we are grateful for your willingness to continue public service, especially at this time.

I wanted to start by talking about an issue that, frankly, we have not spent enough time on over the last decade in terms of what the Federal Government does, and that is home and community-based services.

President Biden's American Jobs plan calls for a bold investment in a great American idea, which is Medicaid-only community-based services. The President has acknowledged what every family in America already knows to be true: caregiving is part of our basic American infrastructure. It is part of who we are; it is how we function. It is part of our efforts to build back better with the emphasis on the word "better." Not the old way, not the way it was in 2019, but better. And I would hope much better.

Just as our society needs bridges, waterways, and roads to function, families need services and supports to care for older family members, to care for people with disabilities, and to care for children. The President's proposal builds on the $12.7 billion of funding for home and community-based services that was made possible when Congress passed the American Rescue Plan.

We know that investing in home and community-based services will, number one, improve the lives of both seniors and people with disabilities. It will at the same time increase wages and benefits for workers; and thirdly, it will create jobs, a lot of jobs across the country.

A majority of these workers are low-income women of color who earn an average of just $12 an hour. An investment in their work is not only long overdue, it is consistent with American values. If we claim to be the greatest country in the world but our home and community-based services are not anywhere near the best in the

world, we cannot say we are the country we claim to be. And for seniors and people with disabilities, access to these services is the difference between simply just surviving and indeed thriving.

So I would ask both Ms. Brooks-LaSure and Ms. Palm one fundamental question, and I am going to ask you both the same question. I would ask for your commitment to work with us to secure funding for these services, the funding the President has outlined, and thereby realize the President's vision for home and community-based services.

Ms. Brooks-LaSure, I will start with you.

Ms. BROOKS-LASURE. Yes; thank you, Senator, for your work on this issue, and so many of the members of this committee. Yes, I pledge to work with you on this.

Senator CASEY. Thank you.

Ms. PALM. You have my commitment as well, Senator. This was a priority in Wisconsin as we looked at the whole continuum of the long-term care system and making sure that we were modernizing and preparing for the needs of the future in this system. And it would be my pleasure to work with you moving forward.

Senator CASEY. Thanks very much. I will stay with Ms. Palm for this question. I am holding a document which I think I have held up when we had a virtual engagement; it is called "Five Freedoms for America's Children." This is a document that our staff worked on for a good long time; we are about to reissue it in an even more ambitious form.

But when I proposed the "Five Freedoms for America's Children"—borrowing directly from Franklin Roosevelt's "Four Freedoms"—we were focused on, of course, this in a domestic context for children. But what we wanted to do was put in place a strategy for America's children. The good news is, in this long, 33-page, 136-footnote document that I am very proud of, some of the proposals in there were achieved in the American Rescue Plan: the great expansion of the Child Tax Credit, for example; the expansion of the Child and Dependent Care Credit.

So I would just ask Ms. Palm if you would make a commitment to working with me—and obviously as one of the leaders of the Department—working with me to get as much of this, of these five freedoms implemented in the time that you serve.

Ms. PALM. I appreciate the question, and certainly your leadership on this issue. I think to your point, if I am confirmed, the Deputy Secretary has the opportunity to leverage across the Department. We touch children in a whole variety of ways, in various programs at ACF, at SAMHSA, at HRSA, and across the board, and I would welcome the opportunity to work with you moving forward on these critical issues.

Senator CASEY. Thanks very much, and, Mr. Chairman, thank you for working with me on all these issues. We are grateful.

The CHAIRMAN. Thank you.

Senator CASEY. I have one question for the record on nursing homes.

The CHAIRMAN. Very good. Thank you for your outstanding work.

The order now is Senator Thune next, followed by Senator Whitehouse and Senator Hassan.

So, Senator Thune.

Senator THUNE. Thank you, Mr. Chairman.

Ms. Palm, I raised this issue with Secretary Becerra when he was in front of the committee, but the topic of 340B is enormously important to hospitals all across South Dakota and across the region; we have three systems that serve the State but also overlap into Minnesota and Iowa and Wyoming and Nebraska—places like that.

And that program has been dysfunctional, I would say, for some time now. And we have heard concerns recently from covered entities in my State about actions taken by manufacturers, not reimbursing contract pharmacies, all of a sudden deciding to dispense with that—which they have questionable authority to do—and now PBMs that are imposing conditions on hospitals in order to get reimbursed, to get payment. And that affects their ability to continue to provide a robust community benefit.

So it is an issue that has been hanging around for a long time; it is a program, obviously, that Congress has expressed support for in law, and it seems like a lot of the entities that are designed to make it work are trying intentionally to undermine the program.

So I am curious, if confirmed, how the Department would respond to ensure that covered entities are not harmed by these actions taken in that sort of supply chain, if you will, both manufacturers and PBMs.

Ms. PALM. Thank you, Senator, for this question. And you are right. I recall from my previous time at HHS that the 340B program was often a topic of conversation, and a challenge. So you are right, there are things we can and need to be doing in this space.

I think to your point, it is a critical program for our safety net providers and for the low-income folks who are able to access drugs through the program. And I, if confirmed, would look forward to the opportunity to make sure that the program is working as it is supposed to be working, and that the oversight and implementation are appropriate so that we really are implementing legislative intent and getting to our safety net providers in low-income communities the access that they need.

Senator THUNE. Thank you. And I am going to hold you to that and follow up with you. But thank you for that answer. You are absolutely right, it needs to be fixed, and I hope that, once confirmed, you will help us get on top of this issue as quickly as possible.

Let me just ask you too, if confirmed: the Indian Health Service is one of the many operating divisions that would fall under your purview. As you may know, for several years IHS facilities in the Great Plains region have struggled with staffing and quality-of-care issues.

Could you discuss your approach for how you would manage IHS, drive quality improvements, and ensure accountability to Congress? And maybe the follow-up to that, would you support legislation that would enable IHS to terminate poor-performing employees, and also to streamline the hiring process to enable the recruitment of talented health-care professionals?

Ms. PALM. I really appreciate the question, Senator. I think that IHS is such a unique part of the Department of Health and Human Services, and when I served previously, I had the opportunity to

visit an IHS facility in your State, and so I certainly understand firsthand the need for the work that is before us to make sure that our tribal communities are receiving the high-quality care that they need.

So I would look forward—I really appreciate you prioritizing this, because there is important work that needs to be done here to meet our mission at HHS as it relates to IHS, and I would look forward to working with you, both through the work we can do at IHS, but then you mentioned legislation. I would be happy to work with you legislatively if there are things we need to do in that space as well.

Senator THUNE. Thank you.

And very quickly, Ms. Brooks-LaSure, CMS plays a significant role with IHS as a payer and because of its involvement in accrediting facilities and assessing compliance with quality and safety measures.

Over the years, multiple facilities in my State have lost or were in jeopardy of losing CMS accreditation because of quality issues. What can we do to improve coordination between IHS and CMS in holding facilities accountable for delivering the highest quality of care?

Ms. BROOKS-LASURE. This is a critical issue, and we have to maintain our commitment, as the government, to work with Indian populations to make sure they are getting the care that they need. I pledge to work with my colleague to make sure that IHS and CMS are coordinating well, and, whether it means that CMS needs to provide technical assistance or take other steps, we will work with you on this.

Senator THUNE. Thank you.

And thank you, Mr. Chairman. I would just point out one thing I forgot to mention. North Dakota is also a State that is impacted by all these 340B issues; the regional systems that serve South Dakota also serve North Dakota.

The CHAIRMAN. Thank you, Senator Thune.

Senator Whitehouse?

Senator WHITEHOUSE. Thank you, Mr. Chairman. Welcome to both of you. I have 5 minutes to ask you four questions, so I will try to go quickly, macro to micro.

We have trillions of dollars in debt. Now, 2024 is the first insolvency date for Medicare, and as my perennial graph that I have shown you before shows, something happened in here [pointing to graph] that has saved $6 trillion in Federal health-care spending predicted within the next decade. I think that what happened in here was delivery system reform.

And I am asking that both of you agree that this needs to be a top priority for CMS and HHS, to figure out why that has happened and to do more of it. Do you agree?

Ms. BROOKS-LASURE. Yes, Senator. I think that delivery system reform is critical for addressing costs, making sure that we are delivering the care that people need, and CMS will continue to look at its authority, through the Innovation Center and through the Medicaid program, to continue to work on these issues.

Ms. PALM. I would echo my colleague and would just suggest that it is also the opportunity to put patients at the center of care, as we are thinking about this.

Senator WHITEHOUSE. Second point: ACOs. We have a lot of really wonderful ACOs where I live. I have two of the best-performing ACOs in the country, and it has been a constant battle to defend the ACOs from you guys trying to pick their pockets before they really get the reward of the investment that they have made. We are seeing ACO participation shrinking rather than growing. And you need to make sure that the ACO lead dogs who are crafting a new model of care actually get supported and encouraged so that that model of care can propagate.

Ms. PALM. Senator, you have raised such an important issue, which is that we want to make sure that our private-sector stakeholders want to continue to innovate. And, if confirmed, I will work with you to make sure that our incentives continue to keep innovators wanting to innovate.

Senator WHITEHOUSE. Thank you. We have another project on end-of-life care where we will ask for waivers of some Medicare payment regulations that are frankly stupid when they are applied to this population. And I have been working on this now for 8 years, and every time we get close, there is an administration change or a personnel change or something, and it is imperative to get a CMMI waiver to make this happen.

Will you promise that you will work with me to help me get this CMMI pilot and those requisite waivers?

Ms. BROOKS-LASURE. If confirmed, Senator, I am happy to understand this demo better and work with you on what we can do here.

Senator WHITEHOUSE. Yes; I come into this boiling with frustration because of 8 years of work—and it always falls off the ledge because of a change in the executive branch. And I am going to get this done.

Then the last thing is, we are working with medication-assisted treatment. We have seen telehealth be very helpful in this space. There is an ongoing conversation about the extent to which that telehealth engagement needs to be video conference and when it can be the audio conference. With people who do not have a home to go to, people who are in perilous circumstances of various kinds, the audio can be actually necessary, and often can be mediated by responsible groups that are serving that population.

Can you help me understand the best practices for the video versus audio and also have somebody from HHS and CMS assigned to give me advice on where we should be fighting to draw that line: when is audio okay; when do you actually need it to be video for medication-assisted treatment in telehealth?

Ms. PALM. Yes, Senator, this is a critical issue. So many underserved areas struggle with this distinction; and as much as we have seen telehealth improve care for some, we need to make sure that it really is available for all. I am happy to talk to you and learn more about this.

Senator WHITEHOUSE. I will wrap up with the observation that a lot of people, including our people in our national security establishment, have said that the biggest issues to America actually are the debt and deficits, and they go on to say that it appears that the biggest part in our debt and deficit area is this explosion of health-care expense. So that begs this question of how you draw

down without taking benefits from people and making this really turgid system clear, fast, and efficient and provide people care early so they do not have the expensive care. That to me is just such an important priority. I hope you will see it that way. You may end up being the most important people in government, as I see it, in solving that problem. Thank you.

The CHAIRMAN. Thank you, Senator Whitehouse.

Senator Hassan?

Senator HASSAN. Well, thank you, Mr. Chair; and I want to thank you and our ranking member for this hearing. And to our nominees, thank you both for being here, for your willingness to serve, for the service you have already provided to your country and your State, and to your families too.

And I want to associate myself with everything that Senator Whitehouse just asked you about; and I will just say that I know Senator Bennet asked about the elimination of surprise medical bills. I think that, the passage of that legislation to end that practice, was an example of really patient-focused policy-making. So I would look forward to working with you both as we implement that provision and find further ways to really look at our health-care system from the patient's perspective. And I appreciate very much your willingness to do that.

Ms. Palm, I wanted to start with a question to you. As you know, the COVID–19 pandemic has exacerbated the ongoing substance use disorder crisis in the country. It is critical that Congress and HHS work together to ensure that States receive the funding that they need to support continued access to substance use disorder treatment and services.

Over the past several years, State opioid response grant funding has allowed New Hampshire to dramatically expand access to opioid use disorder treatment and services for Granite Staters. But under the current funding formula, a significant portion of New Hampshire State opioid response grant funding is now at risk.

I am working to ensure that States like New Hampshire do not face dramatic funding cuts that would devastate opioid use disorder treatment programs. Will you commit, Ms. Palm, to working with Congress to ensure that States do not face dramatic cuts in State opioid response grant funding?

Ms. PALM. Senator, I am so grateful for your leadership on this issue, and considering what we have seen with the pandemic—we were making such good progress—we have to double down. And it is critical that States have the funding that they need to continue to provide treatment for opioid use disorders.

Senator HASSAN. Thank you very much.

Ms. Brooks-LaSure, I want to turn to you, and I just want to say that I have two of the most eloquent colleagues in the world, Senators Menendez and Casey, when it comes to talking about home and community-based services.

So I will associate myself with their comments about the importance of it. We know how important it is to individuals and families to have the choice to get their long-term care at home among familiar faces, in their community, and a chance to really interact with their loved ones and control their care that way.

But I want to drill down on a couple of things. Unfortunately, many individuals who receive care in home and community-based settings have really faced unique challenges accessing, for instance, COVID–19 vaccines. And we know that home health workers have struggled to access the personal protective equipment and COVID–19 testing that they need to do their jobs safely. Just as we saw other disparities really highlighted by the pandemic, the disparity in terms of being either a home health-care patient or a home health-care worker has really been exacerbated too.

So, following up on the commitment you made to Senators Menendez and Casey, as CMS Administrator, how would you work with States to better support home health-care workers and individuals who receive home and community-based care during the COVID–19 pandemic?

Ms. BROOKS-LASURE. Thank you, Senator. This issue you raised, and the other Senators have raised, is such a critical issue. We want to make sure that people are in the setting that makes the most sense for them. And if confirmed, you certainly have my commitment to make sure that CMS is doing everything it can do, whether it is approving waivers or working with States to address issues; and I would love to follow up with you on this particular point.

Senator HASSAN. Well, I would look forward to that as well, because it continues to be a really serious issue.

I have one more question, and it is to Ms. Palm. As the Secretary of the Wisconsin Department of Health Services, you emphasized the importance of health data infrastructure in expanding access to COVID–19 testing.

With the continued emergence of COVID–19 variants, ongoing surveillance and health data exchange will be essential for tracking emergent variants and mitigating community spread.

If confirmed, how will you leverage the tools at CMS or throughout the Department to incentivize health data modernization and improve data exchange?

Ms. PALM. It is such an important question. I think, more broadly, our data infrastructure, our technology, our modernization of the way we think about surveillance and data is critical, and it is a place where HHS can and should help be a leader, so that we are learning the lessons of what our data infrastructure could do and could not do; what we need it to do; where we could partner with the private sector to really maximize our ability to understand community spread in the example you gave; and how that helps us get in front of the next surge or the next community that is facing an outbreak.

And so there is a lot of opportunity there, and I think we really have to be focused, learn the lessons, and drive that into the next iteration of how we work on data and the transparency of that data moving forward.

Senator HASSAN. Thank you very much. I look forward to working with you on that.

Thank you, Mr. Chair.

The CHAIRMAN. I thank my colleague.

Next is Senator Daines.

Senator DAINES. Thank you, Mr. Chairman.

Due to the open-border policies of this administration, we are experiencing a public health and, sadly, humanitarian crisis at our southern border. I saw it firsthand myself; other Senators on this committee in fact were there as well, including Senator Cornyn just a few weeks ago.

We had a chance to talk face-to-face with the border patrol agents, who are overwhelmed by the influx of migrants at the border. The Donna, TX facility has a capacity of 1,000. With COVID, they reduced that number to 250. There were 4,200 migrants in that facility the day we visited, about 2½ weeks ago.

If confirmed, you will help oversee the agency that handles care for unaccompanied children.

Ms. Palm, do you think the current situation at the southern border is a crisis?

Ms. PALM. Senator, I am so grateful that you raised this. This is one of the most pressing issues that HHS is working on right now; and should I be fortunate enough to be confirmed, I look forward to being part of helping get these children through the system and placed in safe places with sponsors as quickly as possible.

Senator DAINES. Do you think it is a crisis?

Ms. PALM. I think it is a very urgent need, and——

Senator DAINES. Have you seen it?

Ms. PALM. I have not been to the border.

Senator DAINES. Have you seen the photos of the children in these overcrowded facilities with no COVID protocols in place? You know, I come from a northern border State. The northern border is still virtually shut down. The southern border had 4,200, many of whom were children, in this facility with a 250-person capacity. A high percentage of COVID transmission is going on, high positive COVID test rates.

Have you seen those photos with really no COVID protocols in place?

Ms. PALM. I have, Senator, and I can tell you as a social worker, the care and safety of those kids has to be our top priority at HHS, and if I am confirmed, I certainly will——

Senator DAINES. And you are aware of what is going on across the Mexican desert with the cartels and the coyotes, the human trafficking, the abuse of these children that is going on as a result of creating an incentive by the Biden administration for them to make that dangerous journey, give their life savings away to the cartels to come across illegally?

Ms. PALM. I think one of the most important parts of the process for us in placing these children with sponsors is that screening, to make sure that those children are going to safe homes, trusted homes, so that we are—so that human trafficking and those abuse issues are screened out.

Senator DAINES. Yes, but once you get across the border, the trafficking issues and the abuse issues have already occurred. This becomes a question of, how do we prevent that and frankly stop it?

Ms. PALM. Senator, I know that there are—my colleagues across the administration are looking at the broader issues at play here, at the root causes and other issues. What I can tell you is, should I be confirmed, our focus at HHS will be on the safety of those chil-

dren's placement in safe homes and finding efficiencies in the system so that we are moving them quickly.

Senator DAINES. Thank you. Do you think that the Vice President, who the President has put in charge of resolving the issue at the southern border, do you think she should be visiting to see firsthand what is happening on the southern border and witness conditions that we all saw here 2½ weeks ago?

Ms. PALM. I think the Vice President has been tasked with a great challenge, and I am sure she is doing everything she needs to do——

Senator DAINES. Why—we are just curious, why wouldn't she go down and see this firsthand? The President has given her explicit responsibilities. And that was 20 days ago. And she has yet to show any interest in actually visiting the southern border; has not shown up.

Ms. PALM. Senator, what I can tell you is, should I be confirmed, I really want to emphasize the priority that we have on placing those children as safely and quickly as possible.

Senator DAINES. Throughout the pandemic, assisted living providers in my home State have cared for over 6,000 vulnerable Montanans, many of who are living with Alzheimer's or some form of dementia.

Due to PPE needs, workforce needs, occupancy deadlines, many of these providers have suffered millions in losses throughout the pandemic and will struggle to sustain their operations without financial relief. There is about $23 billion remaining in the Provider Relief Fund to help support our health-care heroes, who are on the front line of the COVID response. I have urged Secretary Becerra to distribute more of the remaining PRF to assisted living facilities and other senior care centers.

Ms. Palm, would you support that kind of request?

Ms. PALM. Yes; to your point, our front-line health-care workers have borne the brunt of this pandemic. When I was in Wisconsin, we added additional dollars to what the feds were providing to help ease the workload and the burden that they were facing.

Senator DAINES. Thank you.

One final question for Ms. Brooks-LaSure.

I founded this pro-life caucus in the United States Senate. I am deeply committed to protecting the most vulnerable, and that is the unborn. That is why I was troubled to see the Democrats' $1.9-trillion, quote "rescue package" include a taxpayer funding of abortion and numerous provisions, including through Obamacare.

If confirmed, how will you ensure compliance with separate billing requirements for abortion under section 1303 of Obamacare?

Ms. BROOKS-LASURE. Senator, I will, if confirmed as CMS Administrator, absolutely follow the law. And Congress sets that, and whatever the requirements are, I will meet those.

Senator DAINES. And more specifically, will you require recipients of abortion-covering plans with zero-cost premiums due to the expanded tax credits to pay the required abortion coverage surcharge of at least a dollar a month?

Ms. BROOKS-LASURE. Senator, I will follow the law. So if that is the law, I will move forward with whatever you, as Congress, have passed for me to do. Those are my responsibilities.

Senator DAINES. Thank you.

The CHAIRMAN. Thank you, Senator Daines.

Next is Senator Cornyn.

Senator CORNYN. Ms. Palm, as I think the chairman will back me up on this, China has risen to the top of everybody's agenda, out of concerns about cybersecurity, cyber-attacks, stealing intellectual property, espionage, obviously with vast national security implications.

So I will ask you some specific questions in writing later on, but I want to follow up on some of the things that Senator Daines raised, because it has such a dramatic impact on my State and the country.

So, if confirmed, you would oversee the Office of Refugee Resettlement, correct?

Ms. PALM. Yes, as part of the Administration for Children and Families; yes.

Senator CORNYN. And you mentioned that the goal, your goal, would be to place these children, unaccompanied children, with sponsors as soon as you could.

Ms. PALM. Yes. Our mission is to find the sponsors, the families, the relatives to care for these kids while their immigration processes are proceeding.

Senator CORNYN. And after you have placed them with sponsors, is the responsibility of the Office of Refugee Resettlement finished?

Ms. PALM. As I understand it, Senator, yes.

Senator CORNYN. Which government agency monitors the welfare of these children once they are placed with sponsors? Is there any government agency you are aware of that has that responsibility?

Ms. PALM. It is my understanding—and I'm happy to follow up—that if there are concerns once they are placed, State child welfare agencies can become involved in those situations.

Senator CORNYN. Are you aware of the fact that roughly 18 percent of the wellness checks, telephone calls made to the sponsors' telephone number, go unanswered?

Ms. PALM. I did not know that, sir.

Senator CORNYN. Are you aware of the investigation—the Permanent Subcommittee on Investigations of the Homeland Security and Governmental Affairs Committee revealed that some unaccompanied children, once placed with sponsors, I believe in Ohio, were put into a forced labor condition. Have you heard of that?

Ms. PALM. I have heard of that, sir, yes.

Senator CORNYN. So do you share my concern for the welfare of these children once they are placed with these sponsors who may not even be American citizens, who may not even be related to the child?

Ms. PALM. Senator, our mission at HHS is the safety and welfare of those children while they are in our custody; and it is our job to screen those sponsors before placement; and should I be confirmed, I certainly am committed to doing that work.

Senator CORNYN. Well, after they have been placed with the sponsors, who is supposed to protect these children?

Ms. PALM. Senator, as I mentioned, it is my understanding that, if there are concerns beyond the placement, our placement and the

transfer of custody to those sponsors, child welfare agencies may get involved.

Senator CORNYN. So there may or may not be a report to the child welfare agencies if these children are put into a forced labor situation or if they are being trafficked for sex or they are being recruited into gangs? We are supposed to wait on a report from somebody that alerts the child welfare system. Is that correct?

Ms. PALM. Senator, it is my understanding that, if there are concerns post-placement by HHS, child welfare agencies may become involved.

Senator CORNYN. Well, let us talk about while these children are still in the custody of HHS and the Office of Refugee Resettlement. Last week my Governor, Governor Abbot, sent a letter to Vice President Harris with regard to complaints of sexual assault while the young children, I think they are all males, were located at the Joe Freeman Coliseum in San Antonio in an HHS facility.

The complaints outlined multiple allegations involving sexual assault, shortage of staff to supervise the children, and reports that the children were not receiving enough food. There were also complaints that the children who have been exposed to COVID were not properly isolated from other children who were not, had not been exposed.

Obviously these allegations, if true, are extremely disturbing. What steps would you take, if confirmed, to address these sort of allegations?

Ms. PALM. Senator, these are serious allegations and certainly ones that I take seriously. Should I be confirmed—I think there are a couple of things here. From my experience previously but also my priorities moving forward, there is a zero-tolerance policy for abuse in HHS facilities. There is an internal investigation and, because they are mandatory reporters, there also is an external investigation that comes forward. Staff are removed from the facility pending that investigation, and that speaks to the seriousness with which HHS takes allegations around abuse of children in our care.

As it relates to COVID protocols, obviously that is a critical part of reducing the spread of COVID, and it is my understanding that CDC is both providing assistance in the development of those protocols but also that there are CDC folks on the ground at our facilities to help with implementation and to help make sure that what is necessary is being done. But if there are concerns that that is not happening, I would look forward to hearing about them and working with you to make sure that those COVID protocols are in place and implemented.

The CHAIRMAN. The time of my colleague has expired, and we still have other Senators waiting.

Senator Warner?

Senator WARNER. Thank you, Mr. Chairman.

And again, Ms. Brooks-LaSure and Ms. Palm, thank you for your willingness to serve. I have a series of questions.

Over the past decade, a hundred rural hospitals have closed; we have seen three of those in my State of Virginia. Obviously, the pandemic has particularly hit the rural communities extra hard, and rural hospitals extra hard. And it is no coincidence that the

vast majority of these hospital closures occurred in areas with the lowest Medicare area wage index rates.

In Virginia, for example, I have been working for 3 or 4 years in one of our most rural far southwest counties, Lee County, to get a hospital facility reopened. And they have told me point-blank on the path to getting it reopened that fixing the Medicare area wage index would be a huge step in the right direction.

To help solve this problem, we have bipartisan legislation—the Save Rural Hospitals Act of 2021, with Senators Blackburn, Cornyn, and Warnock—which would establish a reasonable match, no-minimum Medicare wage index of .85, which would increase Medicare payments for rural hospitals in 22 States.

Ms. Brooks-LaSure and Ms. Palm, obviously both HHS and CMS would play an incredibly important role. I would like you to both pledge to work with Congress, if you are confirmed, to support rural hospitals by addressing the problem in the Medicare area wage system, and any other comments you might have specifically on how we can guarantee the viability, long-term, of our rural health system.

Ms. BROOKS-LASURE. Thank you, Senator Warner, for your leadership, and for other members of this committee, who I know very much care about your rural hospitals, which are in so many areas, backbones of their communities; and their issues can be different across the different States.

We will absolutely work with you to make sure that we are supporting rural hospitals in the way that is appropriate, and I want to work with you on this topic.

Senator WARNER. And specifically on the—you know, the rubber hits the road on the Medicare area wage system. You will work with us on that issue specifically as well?

Ms. BROOKS-LASURE. Certainly.

Senator WARNER. Ms. Palm?

Ms. PALM. I look forward to working with you, Senator, on this issue.

Senator WARNER. And both are very, very important. And I again think you are going to find broad-based bipartisan support for changing the ratio to the .85 we have suggested; and again, I look forward to working with you both on that.

I want to raise another issue, which is the question around diabetes and diabetes education. I think we all know—you know, one in three Americans has diabetes. My home, in Virginia—we have 631,000 Virginians who have diabetes. To try to educate those individuals—life-style changes have been a bit of a challenge. That national diabetes prevention program, which again CMS has worked with, has shown, I think, great results. The problem has been that, for example in Virginia, we only have one in-person educator for the whole State.

So with COVID coming, we have been able to show, through telehealth, that this is a much more efficient delivery model, oftentimes again to the rural communities we were just talking about. So I have legislation, bipartisan with Senator Scott of South Carolina, that would allow a virtual platform to be used. I do not know if this has come to your attention, Ms. LaSure, but again, it is for both nominees.

I would hope you would be willing to take some of the lessons learned from COVID in delivery of telehealth, particularly on the education side with diabetes. I think this may be one of the areas where we have a better solution set now, and my hope would be that we could make that permanent.

Ms. BROOKS-LASURE. Thank you, Senator Warner. I certainly have heard, across this discussion, how important telehealth is, and what a great example of a clear area where it has been helpful. I really want to work with you and all the members of this committee to see what we can do certainly, if confirmed, administratively, as well as where we might need congressional help.

Senator WARNER. Ms. Palm?

Ms. PALM. I would welcome the opportunity. I think we learned in Wisconsin that these flexibilities and the opportunities to be creative in this space provided us learnings and places where we ought to maintain those flexibilities; and I would look forward to working with you.

Senator WARNER. Mr. Chairman, this is an area I hope I could work with you on as well. I think getting diabetes education on a virtual platform really makes good sense.

The CHAIRMAN. Absolutely, Senator Warner. I think it is hugely important. Thank you.

Our next speaker is Senator Cortez Masto.

Senator CORTEZ MASTO. Thank you. Congratulations to both of you.

Let me just say, in nearly every conversation I have with Nevadans about the pandemic, they mention the toll COVID–19 has taken on mental health and wellness, from students experiencing trauma to isolated seniors, to communities of color who have been hardest hit, and families experiencing severe economic hardship. No one has been spared in Nevada, and similarly across the country.

In my view, addressing these impacts should be at the top of both of your lists. So let me start with—there has been a lot of discussion about telehealth and telemedicine. Count me in; that is something that I have seen in my State that should be permanent. It has brought essential services into our underserved communities.

But one thing I do want to add, Ms. LaSure, is that utilization of telehealth services via telephone without any video is just as important. So I hope, as we look at maybe making this a permanent infrastructure, we recognize the benefits of both, whether it is video or just a telephone, working with a patient. Because that has brought essential services into my communities as well. And I just want to put that on your radar.

Another area I want to focus on is that, unfortunately, we have seen high suicide rates in southern Nevada from some of our students. And recently, I wrote a letter to Secretary Becerra and Secretary Cardona about my concerns over students' mental health and behavioral health. And I asked the Secretaries to work together to ensure that schools are welcoming kids back to classrooms, and they have guidance and best practices at their fingertips that incorporate the wealth of knowledge at HHS on dealing with youth mental health.

So let me ask, Ms. Palm, as the COO of HHS, how will you work to ensure that we are leveraging all of the expertise at the Department, from ACF's work with kids in the child welfare system to SAMHSA's experience in providing trauma-informed care, to make sure that we are spending the American Rescue Plan resources as effectively as possible?

Ms. PALM. I really appreciate the question, Senator, and appreciate your leadership in this space. I think, as we talked about when we met and here today, it is—if I am fortunate enough to be confirmed, I think one of the places where the Deputy Secretary's office has a real opportunity is in making sure that the whole is greater than the sum of its parts; that we really are leveraging the assets and the expertise of the various programs in the Department to really put the people that we serve, the American people, at the center of what we do and the programs that we implement.

And so, whether it is kids' mental health or other issues, we have a real opportunity, and I certainly would look forward to working with you on this issue and others where our coordination and our ability to work together really does better serve the people of this country.

Senator CORTEZ MASTO. Thank you.

And staying on the same theme of behavioral health—crisis services. So last year, SAMHSA released national guidelines for behavioral health crisis care. This playbook is the product of years of work by the agency and draws from innovative projects in communities across the country that are going above and beyond to meet the needs of individuals experiencing behavioral health services.

This tool is so important because it paints a picture of how we can build a sustainable continuum of crisis services that we do not have in Nevada. And similarly, I am hearing from some colleagues across the country.

I started working with Senator Cornyn on legislation that would help States stand up crisis services and make them sustainable by integrating them into both public and commercial insurance plans.

So Ms. Brooks-LaSure, these guidelines are a product of SAMHSA, but CMS will play an integral role in expanding crisis services to patients across the country. Can you speak to what you see as the need for behavioral health crisis services and how you would work with SAMHSA to make sure that those needs are met?

Ms. BROOKS-LASURE. Thank you for raising this issue and for your leadership in this area, as we have been talking about today. What we have seen across our country in terms of mental health is, we had an issue before COVID, and COVID has absolutely had such an effect on so many individuals, and particularly students, as you raise and point out.

One of the things that, if confirmed, I want to make sure of, is that CMS is really integrating very closely with the other parts of HHS and with my colleagues. States in the Medicaid program have a very important role in behavioral health, and many of them are engaging and working in this area. I think certainly in the Medicaid program and others, we want CMS to integrate with SAMHSA to make sure we are tackling this issue holistically as opposed to one part of the agency.

Senator CORTEZ MASTO. Thank you. And I know my time is up. I just want to say, you have heard from the discussion, this is such an important topic for all of my colleagues; we have talked about this in a bipartisan way, as you can imagine. We look forward to working with you to really bring additional resources that are necessary to address behavioral health needs across this country.

Thank you again, and congratulations on your nominations.

Ms. BROOKS-LASURE. Thank you.

The CHAIRMAN. I thank my colleague.

Senator Warren is next.

Senator WARREN. Thank you, Mr. Chairman, and congratulations to our nominees.

It is no secret that our health insurance system, even in the best of times, leaves millions of people without the coverage that they need. But because most Americans still depend on their jobs to provide health coverage, our system performs even worse in a crisis like the one we are now living through.

Heading into 2020, nearly 30 million people were uninsured. Then when the coronavirus hit, unemployment spiked, and up to 3 million more people lost their employer-based insurance.

Now President Biden has promised to expand health coverage, and public programs like Medicare that provide high-quality care at low cost will be the backbone of that expansion, not for-profit insurers that will find any opportunity to shift costs to patients while they line their own pockets.

So, Ms. Brooks-LaSure, you have testified previously about the popularity of the Medicare program. Americans aged 65 and up, and some people with disabilities, are eligible for Medicare right now, but there are a lot of people, many just below the eligibility age, who struggle to get high-quality, affordable care through private insurance.

Can you just say a word about what are the challenges facing older Americans who may want Medicare but have not hit their 65th birthday yet?

Ms. BROOKS-LASURE. Thank you, Senator Warren, for your leadership in making sure that policy-makers continue to focus on making sure coverage is affordable in this country. The Affordable Care Act was such an incredible, important first step in making sure that people had affordable care options. The Congress has just passed the American Rescue Plan—thank you for that—which is making such a difference to people on the ground right now who, as a result of the COVID pandemic, may be struggling to pay for their health insurance.

Being right below the Medicare-eligible age can be an incredible challenge for people if they do not have affordable employer-sponsored insurance. In many States, coverage through the marketplaces is available to them, and we need to continue to work to make sure that we have affordable options available for that population in particular, as they may want to make decisions about retirement, make decisions about job changes at that point in their lives.

Senator WARREN. Right. So we have this group of Americans who are not quite old enough yet for Medicare, but who are sometimes

struggling to access health care right now, during the time in their lives when they start to need health-care coverage the most.

As a candidate, President Biden promised to help this group of Americans by lowering the age of Medicare eligibility to 60 years old. And doing so would expand Medicare coverage to roughly 23 million people.

Ms. Brooks-LaSure, analysts have shown that lowering the Medicare eligibility age to 60 could ensure nearly 2 million previously uninsured people would get coverage, and it would help reduce premiums for the current Medicare population because it would add a younger, healthier population to the Medicare risk pool, benefiting the health system overall.

Is that correct?

Ms. BROOKS-LASURE. I am not familiar with that particular study. I do know that the population you are talking about is absolutely one that—I have worked with States where eligibility for various programs could be higher, and we need to make sure that that population has coverage.

Senator WARREN. Well, let me just ask it slightly differently. I understand if you do not know this particular study, but the general principle makes sense.

When we have fewer uninsured people, and when healthier, younger people join risk pools, that is a good thing, right?

Ms. BROOKS-LASURE. Yes, it is a good thing when healthier, younger people join this pool.

Senator WARREN. And more people get coverage.

So, Ms. Brooks-LaSure, do you agree with President Biden that lowering the Medicare eligibility age could strengthen health-care coverage in America?

Ms. BROOKS-LASURE. I think that the President has outlined several important policies, including as you said, the lowering of the Medicare age; and if confirmed, I will work to implement the policies of the administration.

Senator WARREN. All right. And I appreciate your answer. I have to tell you, lowering the Medicare eligibility age to expand coverage and lower costs is a no-brainer. I know President Biden has talked about dropping the Medicare age from 65 to 60, but frankly I think we should go even further. People need low-cost health-care options, particularly as they get older and need more health care.

Dropping the age to 60 could expand Medicare for 23 million people, but dropping the age to 55 could expand it for an additional 14 million people. And doing so has the potential to lower premiums in the Medicare program, and depending on how we structure it, lower premiums for private health insurance too.

So we have this opportunity to expand Medicare coverage to tens of millions of Americans, and we cannot waste it. We need to get this done.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren. And Senator Warren is raising an important point. I was director of the Gray Panthers for about 7 years before I was elected to Congress, and one of the things we always talked about is that Medicare, when it began in 1965, was just half a loaf. It did not cover so many crucial

needs; dental care, for example, which we have seen during the pandemic being a particularly urgent priority.

So I think these are critical issues that we are going to be digging into.

I have a couple more questions, and then we will wrap up. On the chronic care question—apropos again to how Medicare has changed. Back in those Gray Panthers days, I taught gerontology as well. The first question on every exam I gave was, what was the difference between Medicare Part A and Medicare Part B? Because that was it. You had hospitals, you had doctors, and you were basically dealing with acute care.

That is not it anymore. Now the program is overwhelmingly about chronic illness, and it is increasingly headed that way.

So I have a very specific question. Our bill in 2017 finally put a stake in the ground that we were going to update the Medicare guarantee. We did fairly well, in some key pieces. Telehealth would be one—the Trump administration, your predecessor, Ms. Brooks-LaSure, did not do much, but at least we got that position—Medicare Advantage.

But my question to you is, what are the next steps in your view, because it seems to me that one of the next crucial priorities for chronic care is doing more to bring traditional Medicare, which still covers millions and millions of people, into this circle of better care for what is overwhelmingly going to be the future of the program.

What are your thoughts on that?

Ms. BROOKS-LASURE. Thank you, Chairman Wyden, for your leadership in passing the CHRONIC Care Act, and I know that there has been so much analysis on how effective and helpful that is, including an article by the late Robert Pear. And Medicare Advantage has been able to take advantage of the legislation and the work that you have passed.

I think, as Senator Brown mentioned, it is critically important that we bring some of the innovations and advantages to traditional fee-for-service and traditional Medicare. And whether that is something that we can, if confirmed, look at administratively or whether that is something we need to come back to Congress for, I am happy to work with you on this topic.

The CHAIRMAN. Again, I put this in the context, not just if you are confirmed, but when you are confirmed, because we are deeply committed to that. I would very much like you all to assign some staff from the Department to work with us. We will work on a bipartisan basis. Then-chairman Hatch and I did that when we wrote the original bill.

But I just think we have to do more to bring traditional Medicare into the update of what is, I think to the American people, a guarantee of Medicare.

Now, a quick point about prescription drugs, because you have heard this back and forth and the like. I think we know why this is such an acutely important issue to millions of people; they just feel like they are getting mugged at the pharmacy counter.

I mean, insulin prices went up 12-fold in a period of time that was not very long; the drug is not 12 times better. I mean, it is just plain old price gouging.

So I want you to know that what I am in favor of is a policy that has Medicare negotiate on behalf of the more than 60 million Medicare beneficiaries in order to get them a better deal. That is piece number one.

And the second piece, which we focused on here in the Finance Committee, is when big pharma is price-gouging, they are going to lose subsidies. You know, they get subsidies from the Federal Government; if they price gouge on insulin, they are going to lose some of those subsidies.

And so as you all in the administration, when confirmed, debate those issues, I want you to hear from me, we ought to be pursuing both policies: letting Medicare negotiate, because everybody tries to negotiate, it is just common sense; and we cut subsidies when there is price-gouging. That will produce more savings for the seniors and more savings for taxpayers.

Last point, just to send you both off formally, I consider you both to be eminently qualified, and I think people who review this hearing and look at the record will see considerable bipartisanship. And, Ms. Palm, I noted that, if confirmed, you would advance the common-ground agenda. That is pretty conciliatory language. And, Ms. Brooks-LaSure, you indicated that you would work with Finance members on several bipartisan issues like the telehealth question and the 1332 waivers which I talked about at some length; we do not need to do that again. But I appreciated your saying that that would be a priority for you when confirmed, in terms of getting the guidance out.

So, we have had a long hearing today. I just want members to know I am going to support these two nominees strongly. The deadline for Senators to submit their questions for the record is 5 p.m., Friday, April 16th.

And with that, the Finance Committee is adjourned.

[Whereupon, at 1 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF CHIQUITA BROOKS-LASURE, NOMINATED TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for considering my nomination to be the Administrator of the Centers for Medicare and Medicaid Services. And thank you to Senators Booker and Menendez for their kind words.

As a graduate student, one of my first internships was with the Senate Finance Committee. I remember being so awestruck the first time I saw the committee room and the important business being done on behalf of the American people. So, it's incredibly humbling to sit in front of this committee, this time to testify before you as President Biden's nominee to lead CMS.

My career in public service started at the Office of Management and Budget. My portfolio included CMS's budget, the Children's Health Insurance Program, and coverage options for the uninsured.

But after 9/11, everything changed. It did for the victims of that terrible tragedy, their families, and for first responders. It also changed for many of you, and for everyone in government service. For me, my work shifted toward finding coverage for dislocated workers in the wake of the attack. I worked closely with the Treasury Department and key members of the Bush administration to ensure that those impacted by this senseless attack had health coverage during such a vulnerable time in their lives.

It was inspiring to be part of a bipartisan effort to ensure that people who lost jobs as a result of the attack and its impact on the economy were able to get the health care they needed. I took that philosophy of bipartisanship and sense of mission to improve health care for patients and families with me to the House Ways and Means Committee—where I was privileged to work for the members of that committee on five bills that eventually became law. It's the philosophy I took to HHS and CMS—where I led the development of policies needed to implement the Affordable Care Act and expand coverage to more than 20 million Americans.

I've approached my work in the private sector with the same philosophy—working with States and other stakeholders to expand coverage options, especially for those living in rural parts of the country and for traditionally marginalized communities. Today, as we navigate this public health crisis and its aftermath, that philosophy guides me yet again. If confirmed, that is the collaborative, common-sense, results-oriented philosophy I'll take to CMS to address the complex challenges we face.

I am excited by the many opportunities we have to work together to improve health-care quality, lower costs, and promote better access. I am committed to leading the agency in a way that ensures it acts with the utmost integrity and upholds its fiduciary responsibilities. This includes addressing Medicare solvency to protect Medicare for current and future beneficiaries.

We must get the pandemic under control. COVID–19 has put unbearable pressure on front-line health-care workers, put vulnerable seniors and those with disabilities at great risk, and unmasked inequities that persist in our health-care system. I am committed to working with you and with leaders across government to ensure that CMS is supporting patients and providers, including communities of color who have been hardest hit by this pandemic.

But we cannot wait to deliver better care to patients and families. If confirmed, I will work to make the programs overseen by CMS work better together to help the people they serve. Medicare, Medicaid, and coverage on the marketplaces remain the pillars of our health-care system, and there is much we can do to strengthen those programs to improve quality, lower costs, and expand access.

That includes implementing the critical reforms in last December's appropriations bill and in the American Rescue Plan, particularly the prohibition on surprise medical bills, the new emergency rural hospital designation, and the expansion of financial help for working families to buy comprehensive coverage on the marketplaces.

If confirmed, I am also committed to working with you to expand access to innovative therapies, procedures, and models of care. We are living in an era of incredible change as researchers find new ways to conquer disease and improve our quality of life. We must bear in mind though, that innovation is only effective if patients can actually afford it. I will also work with the committee and all of Congress to rein in health-care costs, including for prescription drugs.

Finally, we must think broadly about health equity. During my career, I've seen how communities of color too often experience worse health outcomes, which we've seen so acutely during this pandemic. Last year in April, my own hometown, a predominately black community where my parents still live, experienced higher rates of COVID–19 infections and deaths compared to much of the surrounding communities. If confirmed, I look forward to working with each of you to expand access to quality care for all communities.

I realize that members of this committee may not always agree on the best approaches to solve these challenges. While there may be disagreements on policy, I pledge to work closely with all members of this committee to ensure that our decisions are transparent, our team is accessible, and that CMS closely listens to and respects your views and ideas for how we can ensure that CMS's programs fulfill their mission to best serve patients, providers, and their communities.

Before I close, I'd also be remiss if I did not acknowledge the outpouring of support I've received from women of color from across the country. I am proud that, if I have the honor of being confirmed, I will be the first black woman to lead CMS.

And I wouldn't be here without my family—my husband sitting behind me, my parents and siblings, and the many strong, smart black women and men who came before me. Too often, they weren't given the opportunity to live up to their full God-given potential. But their selfless, often silent sacrifice paved the way for me and so many other women of color. Today, I'm proud that my daughter can see her mother nominated by the President of the United States to lead such a critical agency—and know that she can be anything she wants to be.

Thank you for considering my nomination, and I look forward to answering your questions.

SENATE FINANCE COMMITTEE

STATEMENT OF INFORMATION REQUESTED OF NOMINEE

A. BIOGRAPHICAL INFORMATION

1. Name (include any former names used): Current: Chiquita White Brooks-LaSure; Former: Chiquita Lynn White.
2. Position to which nominated: Centers for Medicare and Medicaid Services Administrator.
3. Date of nomination: February 19, 2021.
4. Address (list current residence, office, and mailing addresses):
5. Date and place of birth: March 17, 1975; Philadelphia, PA.
6. Marital status (include maiden name of wife or husband's name):
7. Names and ages of children:

8. Education (list all secondary and higher education institutions, dates attended, degree received, and date degree granted):

Georgetown University.
Dates Attended: August 1997–June 1999.
Degree Received: Master of Public Policy (MPP).
Date Degree Granted: June 1999.

Princeton University.
Dates Attended: September 1992–June 1996.
Degree Received: Bachelor of Arts Degree (AB).
Date Degree Granted: June 1996.

Willingboro High School.
Dates Attended: 8th–12th grade—September 1987–June 1992.
Degree Received: High School Diploma.
Date Degree Granted: June 1992.

9. Employment record (list all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment for each job):

Manatt Health Strategies, Manatt, Phelps, and Phillips, LLP.
Managing Director.
January 2016–present.
Washington, DC.

CapView Associates (Consulting).
Senior Advisor.
July–December 2015.
Headquarters: Washington, DC; worked from Melbourne, Australia and Falls Church, VA.

Commonwealth Fund.
Author.
June–November 2015.
Headquarters: New York, NY; worked from Melbourne, Australia and Falls Church, VA.

Deakin University.
Visiting Scholar.
May–August 2015.
Melbourne, Australia.

Breakaway Policy (Consulting).
Senior Advisor.
June 2014–January 2015.
Headquarters: Washington, DC; worked from Melbourne, Australia.

U.S. Department of Health and Human Services.
Director of Coverage Policy, Office of Health Reform.
April 2010–December 2012.
Washington, DC.

Centers for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS).
Deputy Center Director and Deputy Director for Policy and Regulation.
December 2012–May 2014.
Washington, DC and Bethesda, MD.

U.S. House of Representatives.
Majority Professional Staff, Ways and Means Committee.
November 2007–April 2010.
Washington, DC.

Avalere Health.
Senior Manager/Manager (September 2003–September 2006).
Director (October 2006–October 2007).
Washington, DC.

Office of Management and Budget.
Program Examiner.
July 1999–September 2003.
Washington, DC.

U.S. Senate.
(Unpaid) Intern, Senate Finance Committee.
January–June 1998 (Estimated).

McCarter and English.
Paralegal.
July 1996–July 1997.
Newark, NJ.

10. Government experience (list any current and former advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments held since college, including dates, other than those listed above):

Advisory: Committee Member, Virginia Health Benefit Exchange (September 2020–present). Upon confirmation, as outlined in my Ethics Agreement, I will resign from this position. My role is advisory; the committee provides advice to the Exchange Executive Director and VA State officials as they develop their State-based exchange in place of the federally facilitated exchange.

Volunteered as one of the two leads for the Biden-Harris Transition Agency Review Team for HHS, October 2020–January 2021.

Consultative: Authored reports for the States of Nevada (January 2021), New Mexico (December 2018 and January 2019), and Oregon (December 2020). Further detail included in response to Question 15.

11. Business relationships (list all current and former positions held as an officer, director, trustee, partner (*e.g.,* limited partner, non-voting, etc.), proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, other business enterprise, or educational or other institution):

The following are current positions. Upon confirmation, as outlined in my Ethics Agreement, I will resign from these positions:

Board of directors, FAIR Health. I have served on the board of directors since Spring 2018. The board of directors provides input on the organization's strategic goals and activities and approves the organization's budget and executive director's salary. We receive regular updates on how the organization is performing against its goals and budget and are updated on personnel matters.

Board of directors, Children's Law Center. I have served on the board of directors since May 2019. The role of the board of directors includes the activities and responsibilities listed above for FAIR Health, with the additional responsibility of fundraising. I am also on the Development Subcommittee which assists with the organization's fundraising efforts, including planning for the annual benefit.

Managing Director, Manatt, Phelps, and Phillips, LLP (income, but not equity, partner).

12. Memberships (list all current and former memberships, as well as any current and former offices held in professional, fraternal, scholarly, civic, business, charitable, and other organizations dating back to college, including dates for these memberships and offices):

Alfred Street Baptist Church.
Member.
2012–present.

Thursday Network, Auxiliary of the National Urban League.
Member.
2001–2005 (Estimated).

Princeton Evangelical Fellowship (now Princeton Christian Fellowship).
Social Chair: 1995–1996.
Member: 1992–1996.

13. Political affiliations and activities:

a. List all public offices for which you have been a candidate dating back to the age of 18.

None.

b. List all memberships and offices held in and services rendered to all political parties or election committees, currently and during the last 10 years prior to the date of your nomination.

Co-led the Coverage Subcommittee within the volunteer Health Policy Committee for the Biden Presidential Campaign, Summer 2020.

c. Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of $50 or more for the past 10 years prior to the date of your nomination.

See Table.

Contribution Description	Date	Amount
OBAMA FOR AMERICA	2012–08–31	$56.00
OBAMA FOR AMERICA	2012–10–03	$56.00
CALONE FOR CONGRESS	2016–04–27	$250.00
PEOPLE FOR DEREK KILMER	2016–04–27	$250.00
HILLARY FOR AMERICA	2016–07–06	$500.00
HILLARY FOR AMERICA	2016–11–07	$120.00
HILLARY FOR AMERICA	2016–11–07	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2017–09–30	$100.00
ROSEN FOR NEVADA	2018–04–30	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–05–29	$1,000.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–03	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–03	$100.00
ROSEN FOR NEVADA	2018–09–30	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–30	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2019–06–10	$500.00
LAUREN UNDERWOOD FOR CONGRESS	2020–02–05	$100.00
DSCC	2020–04–25	$125.00
BIDEN FOR PRESIDENT	2020–04–25	$125.00
LAUREN UNDERWOOD FOR CONGRESS	2020–04–25	$250.00
BIDEN FOR PRESIDENT	2020–04–29	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2020–07–29	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–07–29	$100.00
DNC SERVICES CORP/ DEMOCRATIC NATIONAL COMMITTEE	2020–10–11	$1,000.00
WARNOCK FOR GEORGIA	2020–12–08	$250.00

14. Honors and awards (list all scholarships, fellowships, honorary degrees, honorary society memberships, military medals, and any other special recognitions for outstanding service or achievement received since the age of 18.):

Recognition Award for Ten Years of Federal Service: 2013.

OMB Performance Award: 2002 (Estimated).

Campbell Award for Alumni (Georgetown University): May 2001.

Merit Scholarship (Georgetown University): 1997–1999.

15. Published writings (list the titles, publishers, dates and hyperlinks (as applicable) of all books, articles, reports, blog posts, or other published materials you have written):

Publications

Co-author, Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Options for Nevada Residents, Nevada Legislative Commission, January 2021.

Co-author, "Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models," Oregon Health Authority, December 17, 2020.

Co-author, "State Strategies for Overcoming Barriers to Advance Health Equity," Robert Wood Johnson Foundation's State Health and Value Strategies program, November 25, 2020.

Co-author, "The Federal Government's Response to the Coronavirus (COVID–19) Pandemic: Questions and Answers," Robert Wood Johnson Foundation's State Health and Value Strategies program, April 22, 2020.

Co-author, "Building on the Gains of the ACA: Federal Proposals to Improve Coverage and Affordability," *Health Affairs,* March 2, 2020.

Author, "State Medicaid Buy-Ins: Key Questions to Consider," Robert Wood Johnson Foundation's State Health and Value Strategies program, April 25, 2019.

Co-author, "The Landscape of Federal and State Healthcare Buy-In Models: Considerations for Policymakers," Arnold Ventures, February 2019.

Co-author, "Quantitative Evaluation of a Targeted Medicaid Buy-In for New Mexico," Health Action New Mexico and the New Mexico Center on Law and Poverty, January 31, 2019.

Co-author, "A Promising Strategy for an Affordable Medicaid Buy-In Option in Colorado," Colorado Center on Law and Policy, the Colorado Consumer Health Initiative, and the Bell Policy Center, December 2018.

Co-author, "Evaluating Medicaid Buy-in Options for New Mexico," Health Action New Mexico and the New Mexico Center on Law and Poverty, December 7, 2018.

Co-author, "Medicaid Buy-in: State Options, Design Considerations and 1332 Implications," Robert Wood Johnson Foundation's State Health and Value Strategies program, May 16, 2018.

Co-author, "Manatt on Medicaid: 10 Trends to Watch in 2018," February 7, 2018.

Co-author, "Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California," California Health Care Foundation, February 2, 2018.

Co-author, "State Marketplace Stabilization Strategies," American Hospital Association, January 22, 2018.

Co-author, "Liberating Data to Enable Healthcare Market Transparency: A Guide for Regulators and Policymaker," Novo Nordisk, March 22, 2016.

Author, "Increased Transparency and Consumer Protections for 2016 Marketplace Plans," The Commonwealth Fund, December 22, 2015.

Co-author, "The Insurance Commissioners," Morning Consult Blog, September 2014.

Co-author, "Chapter Three: Quality of Care," *The Healthcare Delivery System: A Blueprint for Reform,* Center for American Progress, October 2008.

Co-author, "The Medicare Drug Benefit in California: Facts and Figures," California HealthCare Foundation, September 2006.

Co-author, "The Medicare Drug Benefit: How Good Are the Options?" California HealthCare Foundation, March 2006.

Co-author, "The Impact of Enrollment in the Medicare Prescription Drug Benefit on Premiums," Kaiser Family Foundation, October 2005.

Co-author, "The Medicare Drug Benefit: Implications for Chronic Disease Care," California HealthCare Foundation, October 2005.

Co-author, "The Medicare Drug Benefit: Implications for California," California HealthCare Foundation, April 26, 2005.

Co-author, "State Disease Medicaid Management: Lessons From Florida," Avalere Health and Duke University, March 2005.

Newsletters

Co-author, "What a Supreme Court Vacancy Could Mean for the ACA," Manatt on Health, October 21, 2020.

Co-author, "House Passes the Heroes Act," COVID–19 Update, May 19, 2020.

Co-author, "ACA 10th Anniversary Infographic," Manatt on Health, March 23, 2020.

Co-author, "Georgia Releases Section 1332 and 1115 Waivers," Manatt on Health, November 20, 2019.

Co-author, "California Supreme Court: Unpaid Wages Are Not Recoverable Under PAGA," Retail and Consumer Products Law Roundup, October 11, 2019.

Co-author, "With 2020 in View, Democrats Outline Healthcare Reform Positions," Manatt on Health, June 19, 2019.

Co-author, "Marketplace Roundup: Recent Federal Marketplace Activity Promotes State-Level Policymaking," Manatt on Health, May 2, 2019.

Co-author, "Medicaid Buy-In and Public Option: The State of Play," Manatt on Health, February 26, 2019.

Co-author, "What's Ahead for Health Policy in 2019," Manatt on Health, January 17, 2019.

Co-author, "Now on Demand: The Midterm Elections' Impact on Healthcare—and Your Organization," Health Update, December 19, 2018.

Co-author, "CMS Promotes New 1332 Waiver Models, States Weigh Options," Manatt on Health, December 19, 2018.

Co-author, "The Midterm Elections' Potential Impact on Healthcare," Manatt on Health, October 24, 2018.

Co-author, "New Webinar Series: The Midterm Elections' Impact on Healthcare," Health Update, October 23, 2018.

Co-author, "New Webinar: Are Medicaid Buy-In Proposals Gaining Traction?", Health Update, September 25, 2018.

Co-author, "State Action on Market Stabilization," Manatt on Health, May 17, 2018.

Co-author, "States Choosing Divergent Paths for Individual Market Coverage," Manatt on Health, April 11, 2018.

Co-author, "New Webinar: America's Multidimensional Opioid Crisis," Manatt on Health: Medicaid Edition, March 28, 2018.

Co-author, "The President's Budget and Shifting Policy on Prescription Drugs," Manatt on Health, February 26, 2018.

Co-author, "What's Ahead in 2018," Manatt on Health, January 10, 2018.

Co-author, "Next Steps on Healthcare Reform," Manatt on Health, August 8, 2017.

Co-author, "Key BCRA Policy Concerns," Manatt on Health, July 25, 2017.

Co-author, "Special Edition: Key BCRA Policy Concerns," Manatt on Health, July 21, 2017.

Co-author, "BCRA Implications: Affordability of Coverage," Manatt on Health, July 11, 2017.

Co-author, "The Better Care Reconciliation Act of 2017," Health Update, June 28, 2017.

Co-author, "Iowa Submits Sweeping 1332 Waiver Seeking Emergency Relief," Manatt on 1332, June 21, 2017.

Co-author, "House Repeal and Replace Bill: The American Health Care Act," Health Update, May 5, 2017.

Co-author, "New Manatt Webinar, Election 2016: Strategic Implications for Healthcare," Health Update, January 23, 2017.

Co-author, "Special Edition: Comparison of Key Repeal and Replace Proposals," Health Update, December 6, 2016.

Co-author, "The Election's Impact on Healthcare: Preparing for Potential Scenarios," Health Update, September 22, 2016.

Co-author, "Transparency and Decision Support for Medicaid Managed Care Consumers," Manatt on Health: Medicaid Edition, June 30, 2016.

Co-author, "Despite Differences in Coverage Markets, Regulatory Alignment Is Increasing," Health Update, June 23, 2016.

Co-author, "Now You Have a Second Chance to Benefit From What Does the Medicare Part B Drug Payment Model Mean for Hospitals, Physicians and Biopharmaceutical Companies?", Health Update, April 26, 2016.

Co-author, "Liberating Data to Enable Healthcare Market Transparency: A Guide for Regulators and Policymakers," Health Update, March 23, 2016.

16. Speeches (list all formal speeches and presentations (*e.g.,* PowerPoint) you have delivered during the past 5 years which are on topics relevant to the position for which you have been nominated, including dates):

I delivered the following presentations but did not have formal prepared remarks or slides for any of these presentations:

Panelist, "Solutions Over Politics: Improving Healthcare for Every American Breakout Session," NEXT: Powered by the NewDem Action Fund, October 14, 2020.

Speaker, "The Midterm Elections: How They May Impact Your Business in 2018 and Beyond," Bloomberg Next Webinar, November 8, 2018.

Panelist, "Healthcare Exchanges," Democratic Attorneys General Association Fall Policy Conference, Nashville Tennessee, September 14, 2017.

Speaker, "The Future of Obamacare Individual Exchange Marketplaces," Leerink Partners' 2017 Global Healthcare Conference, New York, NY, February 16, 2017.

Co-presenter, "The Election's Impact on Healthcare: Preparing for Potential Scenarios," PharmaVOICE podcast, September 15, 2016.

17. Qualifications (state what, in your opinion, qualifies you to serve in the position to which you have been nominated):

My professional background and health policy experience have positioned me to serve as Centers for Medicare and Medicaid Services (CMS) Administrator. I have extensive knowledge of CMS, having worked at the agency as Deputy Director for Policy in the Center for Consumer Information and Insurance Oversight (CCIIO). In addition, I have a considerable amount of Federal Government experience—including my time in Congress, at the Office of Management and Budget (OMB), and the Department of Health and Human Services (HHS)—and I am thoroughly familiar with how these institutions work together to best serve the American people.

I have deep expertise across all of CMS's areas of responsibility, including Medicare, Medicaid, and Affordable Care Act (ACA) coverage. Since the beginning of my career at OMB, I have worked extensively on Medicaid, the Children's Health Insurance Program, and coverage for the uninsured. I also have Medicare experience, most notably from my time at the House Ways and Means Committee, working on Medicare Advantage and Medicare Part D. I was fortunate to play a key role in the passage and implementation of the ACA—first on the Ways and Means Committee, and then in the Obama administration at HHS. In this capacity, I focused primarily on expanding access for the uninsured through the creation of marketplaces, consumer protections for health coverage, and tax credits.

In the private sector, I worked with States, consumer groups, and other stakeholders on options to cover more of the uninsured and underinsured—focusing on policies to expand access to health insurance coverage and working on strate-

gies to address health equity. This work included exploring the role that Medicaid programs can play in addressing maternal mortality—a critical issue disproportionately affecting black and brown women in America. This work has never been more urgent as we have seen longstanding health disparities illuminated during the COVID–19 pandemic.

My role serving as one of the leads for the Biden-Harris Transition Agency Review Team for HHS provided me a clear picture of the work needed to rebuild HHS and CMS. Moreover, this experience made clear the ways that CMS can work better within HHS and across government to address inefficiencies in our system, and also tackle public health crises such as COVID–19 and health inequities.

If I have the honor of being confirmed, my priorities for CMS are integrating—within CMS and between CMS and other parts of HHS—to make coverage more affordable for people and make programs work together for the people they serve. If our health-care system is better integrated, we will not only be better prepared for the next public health crisis, but also better equipped to advance health equity and improve health-care access and coverage. If confirmed, I would seek to advance payment reforms while promoting equity and health-care coverage—and also working with Congress to reduce prescription drug costs for seniors, people with disabilities, and other consumers.

It would be an honor and a privilege to be confirmed by the Senate to lead CMS. And the significance of my nomination and possibility that I would be the first black woman confirmed to this role are not lost on me. After several decades working on health policy on Capitol Hill, in the Obama administration, and in the private sector, I believe I have the experience and judgment needed to lead CMS during this critical time—not only to recover from the pandemic, but to ensure that all Americans have access to quality, affordable health care no matter their zip code.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections (including participation in future benefit arrangements) with your present employers, business firms, associations, or organizations if you are confirmed by the Senate? If not, provide details.

   Upon consultation with and approval by my agency ethics officials, I will receive a performance-based bonus for calendar year 2020 in three installments and an additional contribution to my Manatt, Phelps, and Phillips, LLP defined contribution plan.

2. Do you have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, provide details.

   No.

3. Has any person or entity made a commitment or agreement to employ your services in any capacity after you leave government service? If so, provide details.

   No.

4. If you are confirmed by the Senate, do you expect to serve out your full term or until the next presidential election, whichever is applicable? If not, explain.

   Yes.

C. POTENTIAL CONFLICTS OF INTEREST

1. Indicate any current and former investments, obligations, liabilities, or other personal relationships, including spousal or family employment, which could involve potential conflicts of interest in the position to which you have been nominated.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

2. Describe any business relationship, dealing, or financial transaction which you have had during the last 10 years (prior to the date of your nomination), whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

3. Describe any activity during the past 10 years (prior to the date of your nomination) in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any legislation or affecting the administration and execution of law or public policy. Activities performed as an employee of the Federal government need not be listed.

   In the last 5 years as a managing director at Manatt, I have been involved in legislative and public policy issues at the local and State level (as summarized in my list of publications and discussed in my ethics agreement). I have testified one time before Congress:

   On June 12, 2019, I testified before the U.S. House of Representatives Ways and Means Committee regarding universal health coverage. The hearing was titled, "Pathways to Universal Health Coverage."

4. Explain how you will resolve any potential conflict of interest, including any that are disclosed by your responses to the above items.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

5. Two copies of written opinions should be provided directly to the committee by the designated agency ethics officer of the agency to which you have been nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position.

   I understand that my ethics agreement has been provided to the committee.

D. LEGAL AND OTHER MATTERS

1. Have you ever been the subject of a complaint or been investigated, disciplined, or otherwise cited for a breach of ethics for unprofessional conduct before any court, administrative agency (*e.g.,* an Inspector General's office), professional association, disciplinary committee, or other ethics enforcement entity at any time? Have you ever been interviewed regarding your own conduct as part of any such inquiry or investigation? If so, provide details, regardless of the outcome.

   No.

2. Have you ever been investigated, arrested, charged, or held by any Federal, State, or other law enforcement authority for a violation of any Federal, State, county, or municipal law, regulation, or ordinance, other than a minor traffic offense? Have you ever been interviewed regarding your own conduct as part of any such inquiry or investigation? If so, provide details.

   No.

3. Have you ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.

   No.

4. Have you ever been convicted (including pleas of guilty or *nolo contendere*) of any criminal violation other than a minor traffic offense? If so, provide details.

   No.

5. Please advise the committee of any additional information, favorable or unfavorable, which you feel should be considered in connection with your nomination.

N/A.

E. TESTIFYING BEFORE CONGRESS

1. If you are confirmed by the Senate, are you willing to appear and testify before any duly constituted committee of the Congress on such occasions as you may be reasonably requested to do so?

Yes.

2. If you are confirmed by the Senate, are you willing to provide such information as is requested by such committees?

Yes.

QUESTIONS SUBMITTED FOR THE RECORD TO CHIQUITA BROOKS-LASURE

QUESTIONS SUBMITTED BY HON. RON WYDEN

NURSING HOME QUALITY

Question. The crisis of COVID–19 in nursing homes has been a collision of mismanagement at every level of the industry from government regulators to individual facilities. More than 175,000 people living and working in the Nation's long-term care facilities have died of COVID–19, including more than 130,000 in nursing homes participating in Medicare and Medicaid. The Senate Finance Committee heard from witnesses during a hearing on March 17, 2021 about ongoing issues in nursing homes that negatively affect patient care like understaffing, poor infection control and inadequate emergency preparedness. These issues have persisted for decades and left facilities particularly ill-prepared for a public health crisis like the COVID–19 pandemic. If confirmed, what would you do to improve the care provided in our Nation's nursing homes?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has hit the Nation's nursing homes, and as you noted, nursing home safety is not an issue newly created by the pandemic. Nursing homes' first obligation should be to their residents, and every nursing home that participates in Medicare and Medicaid must meet Federal health and safety standards. If confirmed, it will be a top priority for me to hold nursing homes accountable for providing high quality care to their residents. Thank you for your leadership on this critical issue.

Question. Thorough and publicly available information on the health and safety of nursing homes is essential. I've worked closely with Senator Casey over the last year to push and prod CMS to collect and make public information about COVID–19's impact on nursing homes that participate in Medicare and Medicaid. More recently, Senator Casey and I were joined by Ranking Member Crapo and Senator Scott (South Carolina) to request that CMS begin collecting and disseminating information regarding facility-level vaccination data. I was pleased to see CMS recently take some important steps toward improving transparency—such as requiring reporting of staff vaccination rates—but there is more work to do. For example, the Finance Committee has repeatedly received testimony about the shortcomings of the Five Star System, which was created to provide clear and meaningful information on the quality of nursing homes. Unfortunately, in many cases a "five star" facility may not provide any better care or protection for residents than a one-star home. This system needs to be fundamentally rethought.

Broadly speaking, if confirmed as CMS Administrator, will you support efforts to improve transparency relating to COVID–19 in nursing homes and address the disproportionate impacts of COVID–19 on nursing home residents of color?

And specifically in regard to vaccinations, will you support efforts to provide consumers and Congress facility-level data about the rate of COVID–19 vaccinations in nursing homes?

Answer. If I am fortunate enough to be confirmed, it will be a top priority for CMS to work to address the disproportionate impact of the COVID–19 pandemic on nursing home residents, especially those of color. I will also work to improve transparency, evaluation and accountability, including increasing the available data regarding vaccinations in nursing homes.

Question. For years, press reports and academic research have repeatedly shown the negative impact that private-equity ownership of nursing homes takes on patient care—an issue that has long been of interest to the Finance Committee. Most recently, a study published by the National Bureau of Economic Research found that private-equity ownership of nursing homes was associated with 10-percent higher short-term mortality of Medicare patients, was "accompanied by declines in other measures of patient well-being," and led to 11-percent higher taxpayer spending on a per-patient basis. Despite these issues, patients, families, and regulators are often hard-pressed to untangle when a nursing home is owned—or controlled through various subsidiaries—by a private equity firm. Section 6101 of the Affordable Care Act sought to address the black box of nursing home ownership by setting out statutory requirements to increase the amount of information made available to the public. CMS issued a proposed rule to implement the statute in 2011, but withdrew it in 2012 after receiving comments. At the time, the agency signaled its intention to reissue regulations that addressed the comments, but never did so.

Does private equity's growing role in the nursing home industry, and its impact on care quality, concern you?

Do you plan to increase the transparency of nursing home ownership information, either through implementation of section 6101, or other regulatory requirements and guidance?

Answer. Nursing homes' first obligation should be to their residents, no matter what kind of ownership arrangements they have, and nursing homes participating in Medicare and Medicaid programs must meet required Federal health and safety standards. If confirmed, I am committed to working with you and your colleagues to ensure nursing homes provide high-quality care to their residents.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

DXA REIMBURSEMENTS

Question. Hip fracture is the most devastating fracture that someone with osteoporosis can experience. In Maryland, there has been an 18.5-percent decline in DXA testing of Medicare women since 2008, resulting in too many unnecessary and avoidable hip fracture related deaths each year.

Will you commit to working with me and Senator Collins to improve access to osteoporosis testing by restoring adequate reimbursement for screenings in the physician office?

Answer. Thank you for bringing this issue to my attention. If confirmed, I am happy to work with you and Senator Collins to explore options to encourage osteoporosis screenings.

HOSPICE PAYMENTS

Question. Hospices in Montgomery County, Maryland are at a long-term competitive disadvantage due to a Medicare hospice Federal payment inequity imposed in 2006 by CMS involving the use of core-based statistical areas (CBSAs) when Metropolitan Divisions are present. Since CMS began using CBSAs to determine payment, hospices in Montgomery County have received lower payments than hospices in adjacent counties, or even those in more rural, low-cost parts of the tri-State area.

Using CBSAs in this manner is flawed for the following reasons. Montgomery County has a similar cost of living compared to Washington, DC and shares the same labor market when competing for labor. As a result, hospices in Montgomery County are having difficulty providing the same level of services as hospices in DC, the three nearby Maryland counties, and the neighboring counties of Northern Virginia, all of which are paid a higher reimbursement.

I sought an administration solution to this issue in two delegation letters to CMS in 2017 and 2018 and hospices in Montgomery County have commented on this problem to CMS annually since 2005.

In your role as CMS Administrator, will you commit to work to resolve this problem?

Answer. Thank you for raising this concern. I know you have been a leader in making sure Montgomery County, Maryland is treated fairly. I too want to make sure the Medicare program operates in an equitable and transparent way. If con-

firmed, I would be happy to work with you and others in the Maryland delegation on this issue to make sure your constituents have access to high quality hospice services.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

MENTAL HEALTH SERVICES IN CHILD WELFARE

Question. One of the ongoing challenges in child welfare is the greater need for mental health services including a greater supply of health professionals with knowledge and experience in child psychology. This is true in the need for post-adoption services as well as families we are trying to keep together.

If confirmed, will you commit to working with States to improve coordination between State child welfare agencies and State Medicaid departments to streamline services and supports for children and young people? How would you work to increase the supply of health professionals to better meet children and young people's mental health needs?

Answer. I share your commitment to making quality mental health services available to children and families involved in the child welfare system, including families who adopt children from the child welfare system. If confirmed, I will make it a priority for CMS to encourage better coordination between State Medicaid and child welfare agencies. The pandemic has created challenges for Americans' mental health, especially for children, and increasing the number of providers is an important step to address these challenges. If I have the privilege of being confirmed, I also want to focus on improved coordination with other Agencies in HHS, including SAMHSA, to make sure we are better integrating mental and behavioral health into the health-care system.

HCBS WORKFORCE

Question. In order to strengthen Medicaid's home and community-based services (HCBS), it is essential that we prioritize policies to develop, support, and build our Nation's long-term care/HCBS workforce. We need to find ways to ensure higher wages for our home care workers and direct support professionals, and support their professional development.

If confirmed, will you work with me and other members of Congress, the labor community, and other stakeholders on ways to provide more support for this essential workforce?

Answer. I appreciate your leadership in this area, and I understand we still have a ways to go to make HCBS a reality for seniors and individuals with disabilities in need of long-term care. Developing, supporting and building the workforce is key to ensuring access to these important services. If confirmed, I look forward to working with you and our State partners to champion further progress to rebalance Medicaid's long-term care services and supports, including looking at what we can do together to help bolster the workforce.

CONTINUOUS ELIGIBILITY

Question. Each year, millions of Medicaid and CHIP beneficiaries who enroll in coverage are at risk of losing that coverage as a result of taking on an extra shift or working overtime, simply because their income fluctuates slightly. As a result, these short-term changes set in motion bureaucratic snafus that cause taxpayers to be disenrolled from their insurance. This breakdown in coverage often disrupts treatment plans and undermines the progress of their care, but can also cause significant administrative challenges that result in higher costs for States, providers, and health plans. This can be particularly disruptive for Medicaid beneficiaries using care coordination and care management services, which are interrupted every time a beneficiary is disenrolled.

The Stabilize Medicaid and CHIP Coverage Act—legislation I've introduced with two other members of this committee, Senators Whitehouse and Warren—would ease the burden caused by churn by ensuring beneficiaries can depend on their coverage for a continuous 12-month period regardless of their age.

Do you agree that we should work to minimize churn in health insurance coverage and eliminate disruptions in care that result when a beneficiary churns in and out of coverage?

If confirmed, will you work with me and my colleagues to strengthen the Medicaid and CHIP programs to minimize churn and ensure continued access to care for beneficiaries?

Answer. I agree that reducing churn in health-care coverage is critical to ensuring continuity of care and positive health outcomes. I look forward to working with you on solutions to ensure that beneficiaries have continued access to health-care coverage they can rely on.

MEDICARE ADVANTAGE/PRIOR AUTHORIZATION

Question. Thank you for your commitment to working with me to equal the playing field between traditional Medicare and the Medicare Advantage program. I look forward to collaborating on this effort.

One area where we can create some parity lies in the prior authorization process. Last Congress, I introduced legislation with Senator Thune to establish an electronic prior authorization program in Medicare Advantage (MA) to better facilitate the prior authorization process in MA and improve the timeliness and efficacy of care delivery for beneficiaries and their providers. CMS has issued a notice of proposed rulemaking to establish similar programs in Medicaid, the Children's Health Insurance Program (CHIP), and insurers operating qualified health plans on the federally facilitated exchange under the Affordable Care Act (ACA). Beneficiaries and their providers should not have to jump through hoops in order to access medically necessary services.

If confirmed, will you work with Senator Thune and me to provide additional technical assistance on our legislation so that we can advance improved prior authorization processes that put the patient back at the center of care and reduce barrier to timely access to essential services?

CMS has the legal authority to implement some of the provisions included in the Improving Seniors' Timely Access to Care Act. As Administrator, will you consider regulatory action to move forward with the provisions of this legislation that are within your current authority to implement?

Answer. I believe that ensuring Americans have timely access to health care is critical, and I agree with you that both providers and beneficiaries should not have to jump through unnecessary hoops for access to medically appropriate care. If confirmed, I look forward to working with you, Senator Thune, and other members of Congress on these important issues.

NURSING SCHOOLS

Question. 42 U.S.C. 1395ww(l) provides an important source of support for hospital-based nursing schools across the country. Unfortunately, nearly a decade ago mistakes in the implementation of 42 U.S.C. 1395ww(l) resulted in several hundred million dollars of CMS overpayments. After becoming aware of these prior overpayments, CMS issued Transmittal 10315, requiring the recoupment of funds from hospitals to correct for past program overpayments.

Unfortunately, this has resulted in a situation where hospital-based nursing schools in Ohio and across the country, due to no fault of their own, are required to pay back millions in funds that CMS mistakenly sent out in past years. While this claw-back of funding would be hard for hospital-based nursing schools to endure during normal times, this recoupment effort during the middle of a global pandemic that has decimated hospital revenues and highlighted the importance of our nursing workforce is both impossible and ironic.

I have shared draft legislation with CMS that could help provide relief to these hospital-based nursing schools for the agency's technical assistance. If confirmed, will you help expedite the process for agency feedback on this proposed fix and work with me and my colleagues on a solution that will support our hospital-based nursing schools and their students?

Answer. I am committed to supporting hospital-based nursing schools training the Nation's next generation of practitioners. If I am fortunate enough to be confirmed, I will look into this important issue and look forward to working with you.

DIRECT AND INDIRECT REMUNERATION FEES

Question. Community pharmacists are a critical player in our Nation's health-care workforce, extending essential services to underserved and disproportionately at-risk communities. Especially during the COVID–19 pandemic, pharmacists have

been critical in our efforts to expand access to testing and vaccination services, including long-term care residents and other seniors and Part D beneficiaries.

Unfortunately, the rapid growth of pharmacy direct and indirect remuneration (DIR) fees continues to create uncertainty for the community pharmacies Ohioans rely on for essential services. The use of DIR fees in Medicare Part D has exploded over the past several years, threatening the financial viability of pharmacies across Ohio and the health of the patients they serve. The Centers for Medicare and Medicaid Services (CMS) has estimated that pharmacy DIR fee reform could result in saving Medicare beneficiaries between $7.1 and $9.2 billion in cost sharing burden over the next decade.

If confirmed, will you commit to working with Congress on solutions to address the explosion of DIR fees and support stability for community pharmacies, while ensuring quality and low costs for Medicare beneficiaries?

Answer. Small and rural pharmacies are critical to our Nation's health-care system and have been especially important during the pandemic. It can be hard for these pharmacies to predict retroactive DIR fees. We must do all we can to ensure that Americans can access important health-care services, including from local pharmacies in their communities. If confirmed, I look forward to working with Congress to ensure that community pharmacists have predictability and to lower drug prices for patients and families.

SOCIAL DETERMINANTS OF HEALTH

Question. As was discussed during Thursday's hearing, entities across the health-care and political spectrum are increasingly focused on ways to address the social determinants of health. The Centers for Medicare and Medicaid Services (CMS)—as both a payer and a policy driver—has many tools at its disposal to improve health and drive value by addressing social determinants.

If confirmed, how will you use Federal payment policy—across Medicare and Medicaid and through the Center for Medicare and Medicaid Innovation (CMMI)—to address the social determinants of health, ensure our Federal programs and models address health-related social needs of patients, and support upstream investments in the social determinants of health?

Answer. The COVID–19 pandemic has further exposed the disparities that exist in our society. I understand the CMS Innovation Center is currently testing the Accountable Health Communities Model, which evaluates whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health-care costs and reduce health-care utilization. In addition, if confirmed, I intend to take a department-wide approach to the advancement of equity, consistent with President Biden's charge to Federal departments and agencies, and this would include examination of ways to address the social determinants of health.

REIMBURSEMENTS FOR NEW TECHNOLOGIES

Question. In January 2021, HHS released its Artificial Intelligence (AI) strategy, which reads, in part: together with its partners in academia, industry, and government, HHS will leverage AI to solve previously unsolvable problems by continuing to lead advances in the health and well-being of the American people, responding to the use of AI across the health and human services ecosystem, and scaling trustworthy AI adoption across the Department.

While the growth of technology in health care has the potential to facilitate access to care and improve quality for beneficiaries, it is critical that any strategy to incorporate AI in HHS policy center consumers. As the Department works to leverage AI and incorporate AI applications and other advanced technologies across health care, HHS should use all existing tools, including payment systems, to support the adoption of technology that increases access to and quality of care.

CMS payment policy has lagged behind when it comes to coverage of newer technologies that offer more personalized approaches to diagnosis and treatment, including those that utilize a form of AI. If confirmed, will you commit to reviewing CMS payment policies for disparities in coverage of AI and other new technologies and acting to update payment systems, where appropriate, to ensure access to those technologies that improve access to and quality of care?

Answer. Thank you for raising this important issue. It is incredible what scientific progress has been made with innovative drugs and treatments, and we need to con-

tinue to modernize the Medicare and Medicaid programs to make sure beneficiaries have access to proven new treatments. I understand that in 2019, CMS launched the AI Health Outcomes Challenge, to engage with innovators with harness AI solutions to predict health outcomes for potential use in CMS Innovation Center innovative payment and service delivery models. If confirmed, I commit to continuing to review how CMS can harness new technologies that utilize AI to improve health outcomes for beneficiaries.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. The COVID–19 pandemic has underscored the urgent need to enhance quality in our Nation's nursing homes. The profound loss of life we have experienced over the last year is a tragedy within the broader tragedy of this pandemic. More than 182,000 residents and workers have died of COVID–19 in nursing homes and other long-term care facilities. Well before the pandemic, I worked alongside Senator Toomey to shed light on cases of abuse and neglect in underperforming nursing homes. These nursing homes are part of what's known as the Special Focus Facility program.

My 2019 investigation with Senator Toomey found that this subset of nursing homes consistently fails to provide quality care, and yet not every nursing home that needs it is receiving intervention. We have an obligation to use every tool available to ensure that the residents who live in these homes receive the highest standard of care.

That is why, last month, Senator Toomey and I reintroduced our bill, the Nursing Home Reform Modernization Act (S. 782). Together, we have laid out a bipartisan path forward to strengthen, target and expand oversight and give help and assistance to nursing homes that need it.

Ms. Brooks-LaSure, can I count on you to prioritize making improvements to nursing home quality and to work with me and Senator Toomey to identify how to enhance oversight for the poorest performing facilities?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has hit the Nation's nursing homes, and this is not an issue newly created by the pandemic, as you noted. I agree that nursing homes must provide high-quality care to their residents. Nursing homes' first obligation should be to their residents, and every nursing home that participates in Medicare and Medicaid must meet Federal health and safety standards. If confirmed, it will be a top priority for me to hold nursing homes accountable for providing high quality of care to their residents.

Thank you for your leadership on this critical issue. I know this has been a priority of yours, and I would be happy to work with you and Senator Toomey on this issue if I am fortunate enough to be confirmed.

QUESTIONS SUBMITTED BY HON. MARK R. WARNER

Question. The PACE (Program of All-Inclusive Care for the Elderly) was established by Federal statute to provide the full range of Medicare and Medicaid benefits to seniors who want to remain safely in their homes, rather than enter a nursing home setting. The COVID–19 pandemic bolstered the attractiveness of the PACE program as these programs were able to pivot from providing services in PACE centers toward doing more telehealth and in-home visits, showing that PACE can help maintain seniors' well-being when it is dangerous for them to be in group settings.

We have a number of large and successful PACE programs across Virginia. I have always been a fan of PACE, and Virginia is one of the more active and supportive States for PACE. PACE does have a big runway for growth, considering that more than two million people in the United States qualify for PACE, but only about 55,000 individuals are currently enrolled.

How do you feel about PACE? Do you have a plan for promoting more PACE centers in the States?

Answer. PACE is an important option that helps individuals in need of nursing home-level care to get health care at home or in community-based settings. PACE provides Medicare and Medicaid services under a model of care that includes comprehensive care management. More can be done to encourage the kind of care co-

ordination and alternative to institutional care seen in PACE. If I am fortunate enough to be confirmed, I will look forward to working with you on this important issue.

Question. The American Federation of Government Employees (AFGE) Local 1923, the union that represents employees at the Centers for Medicare and Medicaid Services (CMS), has expressed concerns to my office about unfair labor practices enacted by the previous administration. Specifically, these dedicated public servants have expressed concern they were forced to accept an unfair collective bargaining agreement (CBA) due to the Trump administration's executive orders (EOs) of 2018 and the Federal Services Impasses Panel (FSIP).

If confirmed, will you commit to reexamining this collective bargaining agreement (CBA) to ensure it is fair to the dedicated public servants you will oversee?

Will you also ensure that CMS engages in good faith negotiations with AFGE and that the agency and its managers appropriately implement EO 14003?

Answer. Thank you for raising this important issue. Our workforce is critical to the continued success of CMS's programs. If I am so fortunate to be confirmed, I would like to learn more about the issues that have been raised to your office, and I will look into this issue to make sure CMS employees have the protections they deserve.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

ELEANOR SLATER HOSPITAL

Question. The Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals stopped billing CMS for Medicaid claims in 2019 following a State audit that flagged the need for some technical fixes to the Rhode Island Medicaid State Plan. CMS recently approved an amendment to the State Plan, but the suspension of billing may amount to approximately $60 million of lost Medicaid dollars for my State. I have contacted CMS with number of questions regarding the suspension and the possibility of the State recouping some of the $60 million. Will you commit to providing me with detailed information regarding the billing suspension at Eleanor Slater Memorial Hospital and to working with me to recoup some of the funding that was lost?

Answer. If confirmed, I would be happy to work with you on this issue. Responsiveness and communication with Congress will be a key priority for me, as I understand your important role in helping your constituents.

IMPUTED RURAL FLOOR IMPLEMENTATION

Question. As part of the American Rescue Plan, I championed a legislative fix to restore the imputed rural floor for Medicare hospital reimbursement rates. CMS is responsible for implementing the legislative fix and should include the imputed rural floor in the FY22 Inpatient Prospective Payment System rule. Do you commit to restoring the imputed rural floor in the forthcoming IPPS rule?

Answer. Thank you for your leadership on this issue. I want to make sure we operate the Medicare program in an equitable and transparent way. I know you worked very hard to make sure this was addressed in the American Rescue Plan Act, and I have every reason to anticipate that CMS is working hard to ensure that the provision will be implemented as quickly as possible. I would be very happy to stay in touch with you, if confirmed, on CMS's implementation of this provision.

MEDICAID

Question. Rhode Island's Medicaid 1115 waiver will expire on December 31, 2023. The current 1115 waiver focuses on social determinants of health, long-term services and support rebalancing and alternative payment methodologies. How will CMS work with the State when it is time to renew the 1115 waiver?

Answer. Medicaid is an important lifeline for many American families. Section 1115 demonstration projects, or waivers, are one available tool to States to help test new and innovative policies in Medicaid. I have worked closely with States throughout my career, so I know they face different challenges and need consistency and predictability. If confirmed, I will keep in mind what I have learned working on behalf of States to make sure waiver requests are appropriately evaluated while giving them consistent guidance. I will support State innovation and the ability of States

to test out different models that meet the objectives of the Medicaid program. I look forward to seeing the ideas States bring to the table and will consider each one on its merits.

Question. Rhode Island is committed to alternative payment methodologies, including Medicaid accountable care organizations but the Federal funding for this program is time-limited. What additional funding, policy support or technical assistance will CMS provide to advance alternative payment methodologies?

Answer. Alternative payment methodologies and delivery reform, generally, are so important to moving our health-care system towards one that rewards value over volume. States, like Rhode Island, are often the leading innovators in this effort, and we should be learning from their successes. More integrated and coordinated care can help to improve care and lower costs. If confirmed, I want to work with you to make sure we are pursuing demonstration projects that achieve these goals, and I would be happy to work with you to support States' efforts to innovate in their Medicaid programs.

HEALTH IT

Question. CMS played a leading role in supporting significant HIT infrastructure under the HITECH Act. What resources does CMS need in order to fund new investments in HIT infrastructure that are compliant with interoperability standards?

Answer. Interoperability of patient records is so critical to ensure appropriate coordination of care. We need to improve health information technology across our health-care system, particularly for behavioral health providers—an important issue I know you have worked to address. I look forward to working with you on this issue, including determining what additional resources might be needed, if confirmed.

AFFORDABLE CARE ACT

Question. How will CMS work with States like Rhode Island that fully embraced the ACA to reduce the remaining barriers to universal coverage?

Answer. If I am fortunate enough to be confirmed, it will be a priority of mine to build on the successes of the Affordable Care Act (ACA). The ACA has extended coverage for millions of American families. It is so important that American patients and families be able to afford health insurance, and I appreciate Congress's leadership in taking action through the American Rescue Plan Act to bring down premiums during the pandemic. We need to continue to work on this issue to make health care more affordable. This includes working with States, like Rhode Island, that have been leaders in ACA implementation to learn from their successes and continue to move the ball forward.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. A noteworthy pattern over the course of the pandemic has been the high utilization of telehealth services via telephone, without any video. This flexibility has allowed physicians to keep their doors open and continue treating patients, and vulnerable individuals who don't have access to a smart phone or might struggle with technology are able to seek services.

In your view, is it important that we maintain access to these services for both Medicare and Medicaid beneficiaries who are still unable to utilize in-person care?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe. My brother is a psychologist, and telehealth has really helped his patients get the care they need. If I am fortunate enough to be confirmed, I will be taking a careful look at the telehealth flexibilities under Medicaid and Medicare before the Public Health Emergency ends. During that review, I will pay special attention to the issues of equity and access. I will look at what we can and should extend administratively and where we will need Congress's help to ensure that we bring the lessons learned about telehealth during the pandemic forward to modernize our health-care system.

Question. Medicare Advantage plans serve more than 26 million vulnerable beneficiaries who have similarly benefited from this expansion in telehealth services. I'm concerned that current CMS risk adjustment policies that exclude audio-only diagnoses could hamper MA's ability to serve beneficiaries during this crucial period and

negatively impact the program, its provider partners, and MA enrollees in the future.

Will you further commit to reviewing this policy promptly to ensure that the policy does not negatively impact premiums, benefits, out-of-pocket costs, or the availability of plans in 2022?

Answer. Medicare Advantage serves millions of Americans and is an important option for Medicare beneficiaries. During the pandemic, we have been able to see the value telehealth brings for patients, including those enrolled in Medicare Advantage. If confirmed, I look forward to working with you to ensure that beneficiaries enrolled in Medicare Advantage plans can continue to benefit from these services.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

UNIQUE DEVICE IDENTIFIERS

Question. Although medical device failures are rare, when they do occur, they can create serious health problems and significant financial costs. A 2017 investigation by the Office of Inspector General at the Department of Health and Human Services found that recalls or premature failures of just seven faulty cardiac devices resulted in $1.5 billion in Medicare payments and $140 million in out-of-pocket costs to beneficiaries. Furthermore, the Inspector General was not able to examine the total cost of all device failures because of the lack of information about specific devices in claims data. Instead, OIG examiners were forced to engage in a "complex and labor-intensive audit" to assess the impact of the seven faulty devices. As a result, the OIG recommended that CMS add unique device identifiers (UDIs) to Medicare claims. Including device identifiers on claims transactions would greatly improve the health system's ability to identify risks and reach patients who may be affected by device failures.

The process of adding UDIs to Medicare claims is a complex one, but ultimately will require CMS to agree to act on the recommendations of X12, an entity that establishes accredited standards for claims transactions. X12 recently recommended that the device identifier portion of a medical device's UDI be included on the electronic claims transaction. As the Administrator of CMS, will you commit to implementing X12's recommendation and adding UDIs to Medicare claims?

Answer. Thank you for your bipartisan leadership on this issue. I understand that a revised claims form that includes the device identifier has made it through the first step in the consensus- based process and that the next step is for the National Committee on Vital and Health Statistics to make recommendations. If I am fortunate enough to be confirmed, I would be happy to look into this issue further and to stay in touch about it with you.

ELECTRONIC VISIT VERIFICATION

Question. The 21st Century Cures Act of 2016 included a requirement that States implement electronic visit verification (EVV) systems for certain Medicaid services. EVV systems are designed to certify that personal care services and home health services in Medicaid are actually provided. They must verify the type of service provided, the date of service, the location of the service, the time the service begins and ends, and the identities of the patient and provider. States that fail to implement EVV programs are subject to a 1 percent, incremental FMAP reduction unless they can demonstrate that a "good faith effort" has been made to comply. States were required to begin implementing EVV for personal care services in January 2020, and they must begin doing so for home health services in January 2023.

Since the 21st Century Cures Act was passed, advocates for workers, people with disabilities, older adults, and Medicaid patients have expressed concern about the lack of worker and patient privacy protections in EVV programs. Meanwhile, they have expressed concern about the possibility of States losing Medicaid funding in the midst of the COVID–19 pandemic. As the Administrator of CMS, will you commit to reviewing existing Federal EVV guidance to determine (1) whether worker and service recipient civil rights are adequately protected, particularly with regard to the use of biometric and GPS data and (2) whether existing EVV guidance contributes to workforce shortages, and what improvements could made to the guidance to mitigate those shortages? Will you commit to ensuring that States do not lose funding for critical services via an FMAP decrease during the COVID–19 pandemic? Will you commit to improving existing Federal EVV guidance and considering the

possibility of using the rulemaking process to ensure that worker and service recipient privacy and other rights are protected in EVV programs?

Answer. Protecting the privacy of patients and our health-care workforce is critically important. If confirmed, I will fully examine these issues to determine the administrative or legislative actions that would be needed to make sure that these requirements are protecting privacy and not placing an undue burden on States and health-care workers.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

MEDICARE/MEDICARE ADVANTAGE

Question. During the COVID–19 pandemic, CMS provided Medicare Advantage (MA) plans with additional flexibilities, such as expanding telehealth services, providing beneficiaries with devices to use telehealth and remote patient monitoring, and reducing cost sharing and premiums. How would you work with stakeholders and Congress to continue certain enhanced benefits and flexibilities, which could continue to further the MA program?

Answer. Medicare Advantage serves millions of Americans and its enhanced benefits and plan flexibilities provide important options for beneficiaries who choose to enroll in it. I believe we have to take every approach we can in order to get people the health care they need at an affordable price, including through the appropriate use of telehealth services. Telehealth has been invaluable during this pandemic in helping to keep patients, their providers and their families safe. I want to be sure we take in the lessons from this pandemic, including the value of telehealth, and look at what flexibilities we can and should extend administratively, and where we may need to work with Congress. If confirmed as CMS Administrator, I look forward to working with you to achieve this important goal.

MEDICARE SOLVENCY

Question. Medicare is on a near-term path toward bankruptcy. The HI trust fund could be insolvent in anywhere from 4 to 5 years. Other than during the first few years of the Medicare program's existence, Congress has never allowed the HI trust fund to project less than 4 years of solvency without acting in order to minimize the impact on health-care providers, taxpayers, and beneficiaries. Given the looming fiscal crisis, how soon can we expect a comprehensive legislative proposal from HHS that extends the life of the HI trust fund?

Answer. Medicare solvency is an incredibly important, longstanding issue. I look forward to working with Congress on a bipartisan basis to address this. We will need both short-term and long-term strategies to make sure Medicare remains a bedrock of our health-care system. It is essential that we protect this program for Americans who have spent their lives paying into it.

DRUG PRICES

Question. There is broad concern that establishing Medicare (or other) prescription drug payment amounts using foreign reference prices will harm patient access and stifle innovation. Do you support the use of foreign reference prices in Medicare? Do you view the use of a foreign reference price to set payment amounts as price setting or a form of negotiation?

Answer. We all agree that too many Americans cannot afford their prescription drugs. Lowering prescription drug costs for American patients and families is a priority on both sides of the aisle, as is ensuring that the United States continues to allow for innovation in drug development. I want to work with you and other members of Congress to find ways to ensure patients have access to innovative drugs and bring down prescription drug prices.

CMMI

Question. The Affordable Care Act established the Center for Medicare and Medicaid Innovation (CMMI). There is significant bipartisan support for testing different ways to pay for services to figure out how patients can get better care at a lower cost. However, there is concern that Congress ceded too much authority to the executive branch by allowing CMMI to override statute, especially in Medicare, in the name of a payment change "test."

What are your views on the appropriate use of CMMI authority?

If confirmed, will you commit to ensuring that CMS would not use CMMI to avoid working with Congress?

Considering that many CMMI tests have run for an extended period of time without meeting the criteria for expansion, is there a length of time sufficient to determine if a model works?

With CMMI having a large budget of $10 billion for each decade and little accountability to Congress, what metrics would you use to determine whether CMMI is successful?

Answer. The Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't, and I look forward to hearing from you about what you think is working well and what experiences you've seen in Idaho.

PAYMENTS

Question. There are concerns that the inclusion of calcimimetic medications in the Medicare End Stage Renal Disease (ESRD) bundled payment rate may harm beneficiaries' access to these treatments. There are anecdotal reports that some patients have had to change or otherwise stop using a medicine that has worked for them in response to this payment policy change. How would you ensure that ESRD patients have access to calcimimetic treatments and monitor patient outcomes in this area?

Answer. I agree that is it important for Medicare beneficiaries, particularly patients with complex medical conditions such as ESRD, to have access to medically necessary treatments such as calcimimetics. If confirmed, I will work to preserve access to critical treatments and improve patient outcomes.

Question. In the "Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems" proposed rule for 2021, CMS solicited comments on the use of its "equitable adjustment" authority for pass-through products adversely impacted by the reduction in surgical procedures during the COVID–19 pandemic. Will CMS use this authority to ensure that products impacted by the pandemic receive pass-through payments for a length of time that enables adequate cost data collection that ensures reasonable payment once these products are bundled into an ambulatory payment classification (APC) group?

Answer. The COVID pandemic is taking a toll on Americans in so many ways, including reducing and delaying surgeries. If confirmed, I will work with you and other members of Congress as we look for ways to help providers, suppliers, and other stakeholders recover from the financial impacts of the pandemic and maintain access for beneficiaries.

NEW TREATMENTS

Question. The 21st Century Cures Act that was enacted in 2016 created a home infusion therapy benefit to provide for the nursing services necessary to support drug administration in the home setting when patients are unable to self-administer. To date, no new drugs requiring health-care professional administration have been able to get covered for home infusion. CMS issued a "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues and Level II of the Healthcare Common Procedure Coding System (HCPCS)" proposed rule in 2020 that would create a pathway for drugs requiring healthcare professional administration to be covered for home infusion. This rule has not yet been finalized, even though many seniors would continue to benefit from being able to receive treatment at home during the COVID–19 pandemic. Will CMS prioritize the finalization of this DMEPOS proposed rule to expand seniors' access to the home infusion benefits?

Answer. Thank you for raising this important issue. We share the goal of making sure people can receive care in their homes, when appropriate, especially during the pandemic. If confirmed, I am happy to make the review of this proposed rule a priority.

Question. Cell and gene therapies present a paradigm shift in the treatment of disease, no longer just treating symptoms, but using cutting-edge technology to ad-

dress the root cause of the disease itself. The FDA has previously predicted that it will be approving 10 to 20 cell and gene therapies a year by 2025. Many of the initial diseases that these groundbreaking therapies aim to treat are disproportionately insured by Medicare and Medicaid. The cost of these potentially life-saving therapies has led to a national conversation on the use of value-based arrangements to ensure broader access for beneficiaries, especially for rare disease and cancer patients where the population that is eligible for the therapy could be in the hundreds or thousands.

Would you agree that CMS should do all they can to ensure access to FDA-approved cell and gene therapies when a doctor and a patient agree it is the best treatment option?

As Administrator, would you commit to utilizing existing program flexibility and considering innovative demonstration programs to enable Medicare and Medicaid beneficiaries' timely access to innovative cell and gene therapies? Will you commit to working with Congress on a statutory solution that maximizes access without threatening future development of these innovative products?

Answer. Thank you for raising this important issue. It is incredible what scientific progress has been made with innovative drugs and treatments, and we need to continue to modernize the Medicare and Medicaid programs to make sure beneficiaries have access to proven new treatments. I would be happy to work with you and other members of Congress on ways to spur innovation and facilitate beneficiary access to proven new advances in medicine.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. American taxpayers expect us to be good stewards of Federal money. Under section 1903(u) of the Social Security Act, the Federal Government is required to recoup any improper Medicaid eligibility-related payments in excess of three percent made by States. The Centers for Medicare and Medicaid Services (CMS) has made little improvement since 1992 to recover any of these payments. In 2019, Congress passed the Payment Integrity Information Act requiring CMS to periodically review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, and report on the improper payment estimates. The most recent annual reported improper payments figure across all Medicare and Medicaid/CHIP programs was $134.21 billion (2020 CMS estimated data) and $106 billion (2019 CMS data). The Medicaid improper payment rate for 2020 was 21.36 percent (or $84.49 billion) and the Medicare fee-for-service improper payment rate for 2020 was 6.27 percent (or $25.74). This has been ongoing for decades. If confirmed, how will you as CMS administrator address the improper payment rate and the waste of taxpayer dollars?

Answer. Medicaid is a critical lifeline for beneficiaries across the country and typically the largest expenditure for States. Reducing Medicaid improper payments is a priority because it helps ensure the fiscal health of the program. If confirmed, I will work with States and leaders in Congress to be responsible stewards of taxpayer dollars across both Medicaid and Medicare.

Question. Ensuring access and protections for individuals with serious disabilities who rely on complex rehabilitative manual wheelchairs is important. In 2019, Congress provided 18-month relief for complex rehab technology (CRT) by including protections for complex rehab manual wheelchairs. On June 30, 2021, a temporary policy allowing users of complex rehabilitative manual wheelchairs the same benefits as complex rehabilitative power wheelchair users will expire. This policy has given equal access for the people with disabilities who depend on this new technology. If confirmed, would you support a permanent policy maintaining the equal access between manual and power wheelchairs?

Answer. I agree that is important to make sure Medicare beneficiaries have access to the durable medical equipment they need. If confirmed, I will work with you on this issue.

Question. In 2020, I cosponsored the Temporary Reauthorization and Study of the Emergency Scheduling of Fentanyl Analogues Act and it was signed into law. The law extended the Drug Enforcement Administration's temporary scheduling order to proactively control deadly fentanyl analogues. Fentanyl-related overdose deaths continue to rise and sophisticated drug trafficking organizations manipulate dangerous substances to skirt the law, so this critical law placed fentanyl substances in Sched-

ule I so that they can be better detected and criminals can be held accountable for their actions. The law sunsets in May of 2021. In December 2019, 56 other State and territory attorneys general asked Congress to permanently codify a temporary emergency scheduling order keeping fentanyl-related substances classified as Schedule I drugs. If confirmed, do you support permanently codifying a temporary emergency scheduling order keeping fentanyl-related substances classified as Schedule I drugs?

Answer. I recognize that fentanyl and fentanyl analogues pose a significant danger and are responsible for far too many deaths every year. While CMS does not have a role in the scheduling process, I understand that HHS plays a key role that effort.

Question. Science tells us that an unborn child has many of the neural connections needed to feel pain, perhaps as early as eight weeks and most certainly by 20 weeks fetal age. Providing health care to unborn children and their mothers can help reduce infant mortality rates in low-income communities, research also suggests. Some States already offer prenatal care and other health services to unborn children through the Medicaid program. What is your view on whether unborn children should be entitled to Medicaid coverage, and do you believe that the Federal Government has a role to play in encouraging such coverage?

Answer. Medicaid is an important source of pre- and post-natal care, and if I am confirmed, I will work to ensure that pregnant people have access to quality health care that improves their own health and the health of their babies. I was happy to see that Congress included incentives for States to expand Medicaid postpartum coverage in the American Rescue Plan and that CMS has approved section 1115 demonstration projects to this effect. I look forward to working with members of this committee and Congress to expand access to affordable, quality care, including through the Medicaid program.

Question. Congress's ability to acquire information from Federal agencies is critical to its constitutional responsibility of conducting oversight of the executive branch. If you are confirmed, will you commit to providing thorough, complete, and timely responses to requests for information from members of this committee, including requests from members of the minority?

Answer. If confirmed, I will provide responses to requests from any members of this committee.

Question. In 2019, Congress passed bipartisan the Advancing Care for Exceptional (ACE) Kids Act to improve health outcomes and care coordination for children with complex medical conditions in Medicaid. In 2020, I introduced the bipartisan Accelerating Kids' Access to Care Act to further help families gain access to life-saving care for children with complex medical conditions. The legislation aims to facilitate access to care while retaining program safeguards and reducing regulatory burdens on providers. If confirmed, what steps would you take to improve the system of care for children with complex medical conditions?

Answer. Thank you for your leadership on the ACE Kids Act and your focus on access to care for children with complex medical needs. I agree that we should do all we can to remove barriers to care for these children. If I am fortunate enough to be confirmed, I will look forward to working with you on solutions to ensure children with complex medical needs get the best care possible.

Question. In Iowa, transitional health plans (including grandmothered health plans) have enabled many middle class Iowans to keep the health plans and doctors they like at a reasonable price since the Affordable Care Act was implemented. For example, over 56,000 Iowans are covered by grandmothered health plans. To put this in context, about 60,000 Iowans signed up for the Federal health insurance exchange in 2021. Iowans have chosen these grandmothered health plans that meet their individual needs. Currently, grandmothered health plans' existence is determined by the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS) annually through non-enforcement extensions. If confirmed, are you committed to maintaining these affordable, consumer-chosen health plan options for Iowans by extending the non-enforcement authority?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine rules and other policies to ensure all Americans can access the care that they need, and I look forward to learning more from you about what is working in Iowa.

Question. Since this COVID–19 pandemic began, the Department of Health and Human Services (HHS) including within the Centers for Medicare and Medicaid Services (CMS) has provided health-care providers and patients many flexibilities under the public health emergency authority including over 80 services now furnished through telehealth for Medicare patients. A Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report found the use of telehealth increased 154 percent during the last week of March 2020 during the emergency of COVID–19 compared to the same period in 2019. We know the use of telehealth has continued throughout the COVID–19 pandemic. The data and response from patients and providers prove permitting telehealth services is a positive action to improve access and care. This last Congress, we provided permanent coverage for mental health telehealth visits under Medicare, which is helpful during the pandemic and will remain critical for many Americans afterwards. If confirmed, are you committed to working with Congress and in the executive branch to extend telehealth flexibilities in Medicare beyond the pandemic? Additionally, some providers, including community health centers, face regulatory barriers based on provider type or site of service. If confirmed, do you support removing those telehealth barriers for certain providers?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe. My brother is a psychologist, and telehealth has really helped his patients get the care they need. If I am fortunate enough to be confirmed, I will take a careful look at the telehealth flexibilities under Medicaid and Medicare before the Public Health Emergency ends. During that review, I will pay special attention to the issues of equity and access. I will look at what we can and should extend administratively and where we will need Congress's help to ensure that we bring the lessons learned about telehealth during the pandemic forward to modernize our health-care system.

Question. As a direct result of the Affordable Care Act's one-size-fits-all approach, many Iowans have been priced out of health insurance. To rectify this, the Trump administration and Iowa Insurance Division enabled Iowans more choice and competition in the health-care marketplace by enabling and expanding short-term limited-duration insurance (STLDI). This gives Iowans access to health insurance with consumer protections. If confirmed, will you work to maintain, modify, or rescind the current regulations enabling Americans to purchase STLDIs?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine rules and other policies to ensure that plans provide Americans access to the care that they need.

Question. It is important to give people affordable options for health insurance. Small business owners, like Iowa farmers, want to be able to provide insurance for their employees. Association Health Plans are a way for these small businesses to band together to expand access to health insurance and drive down costs. I have introduced legislation and support efforts to expand the pathway to affordable and accessible health care remaining open to employees across America. Association Health Plans allow small businesses to join together to obtain affordable health insurance as though they were a single large employer. The coverage offered to association members is subject to the consumer protection requirements that apply to the nearly 160 million Americans who receive coverage from large employers. If confirmed, will you work to maintain, modify, or rescind current regulations enabling employers and employees access to Association Health Plans?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine all rules and policies to ensure all Americans can access the care that they need.

Question. I support access to affordable health-care coverage for all Iowans, regardless of their health status or pre-existing conditions. Americans want to be in control of their own health care. National, single-payer health systems do not allow that. The Affordable Care Act took options away from people and adopting a single-payer system will make that worse. A national, single-payer health system would eliminate private health insurance for nearly 200 million Americans and require middle-class Americans to pay much more in taxes. Single-payer health care would also dramatically increase government spending substantially, fail to meet patient needs quickly, reduce provider payments rates and reduce quality of care, and the government would have more control over health care. It also threatens the benefits that current seniors on Medicare have paid into the system their entire working lives. If confirmed, do you intend to take administrative actions to implement the

vision of a one- size-fits-all government-run health-care scheme like single-payer? If so, please describe what authority you believe you have to take such actions?

Answer. President Biden has made it very clear that his goals for improving the American health-care system begin with building on the successes of the Affordable Care Act, and I am committed to working toward that goal.

Question. If confirmed, will you take actions that stifles innovation and competition in health care?

Answer. I believe it is important to foster innovation and competition in our health-care system. CMS has a critical role in promoting these goals and ensuring access to care. Americans should have access to health-care services and products at an affordable price.

Question. In 2019, the Trump administration issued two rules requiring price transparency for hospitals and health plans. The rules took effect in January 2021. This effort shines a light on the health-care industry that is all too often shrouded in secrecy. While Congress can build upon the rules, consumers can finally see sunshine in health-care pricing. I have cosponsored legislation to codify the two health-care price transparency rules. This transparency will bring more accountability and competition to the health-care industry. Consumers should have the ability to compare health-care prices online so they can make an informed choice about what's best for them and their families. If confirmed will you modify, rescind, or maintain the Trump administration's health-care price transparency regulations?

Answer. I agree that the variation in pricing across hospitals is not always justified and ultimately can be bad for consumers. For transparency measures to work properly, patients and their families must be able to understand them in a meaningful way. If I am fortunate enough to be confirmed, I look forward to continuing to work on this issue.

Question. Some States have lacked transparency in reporting their nursing home COVID–19 deaths data. For example, the State of New York undercounted nursing home deaths by as much as 50 percent and State officials intentionally withheld data for months. The New York Attorney General Letitia James released a report in January 2021 suggesting that many nursing home residents died from COVID–19 in hospitals after being transferred from their nursing homes. These figures were not reflected in the New York Department of Health's nursing home death figures for many months suggesting the State was undercounting by as much as 50 percent. There are also reports finding New York State officials including members of New York Governor Andrew Cuomo's staff intentionally withheld data on COVID–19-related deaths in the State's nursing homes. Following the release of the New York Attorney General report, the New York Department of Health reported 12,743 nursing home residents occurred. This included an additional 3,829 confirmed COVID–19 fatalities of those residents who had been transported to hospitals. I have warned President Biden that an across-the-board termination of 56 U.S. attorneys could imperil ongoing sensitive investigations. This concern has been expressed by Senate Democrats. Currently, Toni Bacon is serving as the U.S. attorney for the Northern District of New York. Ms. Bacon previously served as Justice Department's national elder justice coordinator and who currently has jurisdiction over Federal public corruption crimes in the State. Bacon is the obvious choice to continue a fair and unbiased investigation into possible violations of civil liberties of the elderly and the public corruption. Do you believe Department of Justice must have a fair, unbiased, and experienced U.S. Attorney in the Northern District of New York, such as Ms. Bacon?

Answer. I defer to the Department of Justice on the selection of U.S. Attorneys.

Question. I led an effort in the Senate making additional resources available to support elder justice initiatives that assist older Americans especially throughout the COVID–19 pandemic. During the 116th Congress as Senate Finance Committee chairman I convened two hearings on elder justice initiatives and gaps in nursing home oversight. In December 2020, I urged Senate leadership to make resources available for regional or statewide strike teams to support nursing homes in crisis during this pandemic. Through this work, the end-of-year COVID–19 relief package included $100 million to support elder justice initiatives, including $50 million for State adult protective service agencies as they cope with unique challenges of serving vulnerable populations during the pandemic. This work includes nursing home strike teams who have provided needed support when an outbreak occurs at a nursing home or when additional resources are needed to meet the infection control or diagnostic testing requirements. Have State or Federal nursing home strike teams

been effective at controlling outbreaks and protecting vulnerable Americans? If so, can you describe how their work slowed the spread and protected lives?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has hit the Nation's nursing homes. Nursing homes and long term care facilities are the homes for some of our most vulnerable, and we must do everything we can to work to protect them. If confirmed, I look forward to reviewing the work of the Federal nursing home strike teams.

Question. The global pandemic has exposed grave concerns our society must confront to protect the Nation's most vulnerable citizens. Approximately 1.4 million Americans live in about 15,000 nursing homes across the country. Many Iowans have a loved one who lives in a long-term care facility. In 2019, as chairman of the Senate Finance Committee, I conducted a series of hearings to examine gaps in enforcement of nursing home abuse. A Government Accountability Office (GAO) investigation found a 103-percent increase in abuse deficiencies between 2013 and 2017. The GAO noted abuse in nursing homes is often underreported. The report documented physical, mental, verbal and sexual abuse perpetrated against residents. The number of nursing home deaths attributed to COVID–19 delivers a wake-up call we can't afford to ignore. The Federal Government needs to do a better job enforcing compliance with standards of care. When a loved one requires a long-term care facility to deliver around-the-clock services, every family deserves peace of mind that every nursing home resident will receive high-quality, compassionate care and be treated with dignity and respect. If confirmed, how will you as administrator ensure nursing homes uphold the standard or care that is necessary while not placing onerous requirements and excessive administrative burdens on nursing home staff?

Answer. Thank you for your longstanding leadership on this important issue of preventing elder abuse. This will be a focus of mine if confirmed. Nursing homes and long-term care facilities are the homes for some of our most vulnerable, and we must do everything we can to work to protect them.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

END STAGE RENAL DISEASE

Question. Four hundred thousand Medicare beneficiaries are on dialysis, and those patients have not benefited from any meaningful innovation in their standard of care in decades. Over the last several years I have joined colleagues on both sides of the aisle and worked with CMS, the patient community and innovators to encourage adoption of a new policy to spur innovation in medical technology for Medicare patients under the ESRD bundled payment system. CMS has made significant progress, having created the TPNIES add-on payment for innovation in medical technology used in the provision of dialysis services. However, our work is not done. CMS should better align its metrics for innovation and clinical improvements over existing technologies with the lens FDA uses to evaluate such improvements and innovations. And CMS should also extend by another year the period of time during which the add-on payment can be made, having established an application and qualification process via rulemaking that essentially negates the first year of the add on payment window. I will again work with my colleagues on legislation to make these additional improvements to the work CMS has already done, and hope that you will commit to working with me to achieve full success on this policy for Medicare patients in whatever is the most expeditious and achievable path.

Will you commit to working with Congress to implement these policies and bring long overdue innovation to this vulnerable group of patients?

Answer. I agree that it is important to spur innovation in medical technology that improves health outcomes, particularly for patients with complex illnesses such as ESRD. I will always look for ways to improve access to innovative and effective treatments for ESRD patients, and I believe there is plenty of room for bipartisan work in this area. If confirmed, I will work with you and other members of Congress on ways to improve access to these innovative treatments.

MEDICARE PROGRAM INTEGRITY

Question. I'm very concerned about the billions of Medicare funds lost to errors, waste, fraud, and abuse. Previously, CMS expressed the need to "elevate program integrity, unleash the power of modern private sector innovation, prevent rather

than chase fraud, waste, and abuse through smart, proactive measures, and unburden our provider partners so they can do what they do best—put patients first." Also, Congress included language in the Fiscal Year 2021 appropriations encouraging CMS "to consider pilot programs using AI-enabled documentation and coding technology to address CMS's top program integrity priorities and reduce administrative burden." I think we can do more to harness the expertise used in the private sector to benefit our Medicare beneficiaries and safeguard the Medicare Trust Fund. I hope this is an area of policy that we can work on together.

Will you commit to working with this committee to prioritize the use of artificial intelligence and other emerging technologies to bolster Medicare program integrity and protect the Medicare Trust Fund?

Answer. Fighting fraud and abuse is important for maintaining a strong Medicare program. It is my understanding that CMS has taken steps to explore the possibilities of artificial intelligence for program integrity purposes in addition to a host of other tools it uses to detect waste, fraud and abuse. If confirmed, I will work with you to make sure that we are good stewards of the Medicare program and taxpayer dollars.

BUNDLED PAYMENTS

Question. CMMI has recently expressed their commitment to value-based payment programs but is no longer allowing new participants in the BPCI model and last week announced they won't take new applicants to the new direct contracting model. This is creating uncertainty about the agency's commitment. My constituents have made substantial investments in participating and/or preparing for these programs and strongly believe in their importance in driving value for Medicare beneficiaries and the trust fund.

Can you assure me as CMS Administrator that you are indeed committed to these innovative models and that you will be open to stakeholder input to improve upon CMMI models before canceling them?"

Answer. The Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't and chart a path forward from there. This absolutely includes getting stakeholder and congressional input. If confirmed, I will work with you to make sure we are pursuing models that recognize the strides providers have already made and improve our health-care system.

LABORATORY DATE OF SERVICE POLICY

Question. In 2017, CMS established regulations at 42 CFR §414.510(b)(5) to revise its date of service policy for clinical laboratory tests to allow a laboratory to bill Medicare directly for molecular pathology tests and certain Advanced Diagnostic Laboratory Tests (ADLTs) (as defined under section 1834A(d)(5)(A) of the Social Security Act) performed on specimens collected from hospital outpatients. These regulations eliminated access delays for Medicare beneficiaries that resulted from the previous requirement that the hospital at which the specimen was collected bill Medicare for these relatively uncommon tests. Under the current policy, hospitals and SNFs are similarly incentivized to delay submitting samples which can have an impact on patient care and time to treatment.

Can you commit to working in future rulemaking to address this payment policy for skilled nursing facilities and inpatient hospitals as the agency has already done in the outpatient setting?

Answer. I share your desire to protect Medicare beneficiaries' access to laboratory testing services. My understanding is that payment to a hospital or skilled nursing facility for laboratory tests furnished to an inpatient whose stay is covered under Part A is generally included in the prospective payment system rate for the facility. If I am fortunate enough to be confirmed, I would be happy to hear more from you on this important issue and work with you to improve beneficiary access to laboratory testing.

SURPRISE BILLING

Question. Complex molecular diagnostic tests for advanced cancer have tremendous benefit for patients and oncologists hoping to identify the best treatments.

Many of these tests are viewed as out-of-network and have limited comparable tests for setting benchmarks.

Can you commit to working with my office to make sure that access to these important tests is not delayed due to surprise billing regulations promulgated under the No Surprises Act?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. I know that there will be a lot of work to do to implement the No Surprises Act. If confirmed, I look forward to working with you and other members of Congress to make sure that consumers are protected from surprise bills while ensuring they have access to the care that they need.

DISPROPORTIONATE SHARE HOSPITALS PAYMENTS

Question. Disproportionate Share Hospitals (DSH) are owed more than $10 billion in reimbursements going back to 2005. CMS has challenged these payments based on a formula that defied congressional intent. The court have consistently ruled that CMS's interpretation is wrong and therefore its rule making is invalid. The agency continues to fight and is planning to issue yet one more rule despite a loss on this issue at the Supreme Court.

Will you commit to working to ensure DSH hospitals receive the DSH payments they are owed.

Answer. Disproportionate Share Hospitals are critical to our Nation's health-care system, providing care to low-income patients and the uninsured, and I know that this pandemic has placed significant pressure on these health-care providers. If confirmed, I look forward to working with you and other members of Congress to ensure CMS is using taxpayer dollars appropriately while supporting these providers and the work they do on behalf of their patients. I will also ensure that States and providers have the guidance they need to administer and participate in the Medicaid program.

DIALYSIS-RELATED AMYLOIDOSIS

Question. We have watched for years as the Medicare program has delayed coverage for important medical breakthroughs offered by both prescription drugs and medical devices. Although we are aware of certain improvements over the past 2 years in the coding process for new drugs and devices, the coverage process lags far behind. The result is that patients are not receiving the care they need.

One recent example involves Dialysis-Related Amyloidosis (DRA), a disease that affects an estimated 3,000–5,000 patients who have been receiving dialysis treatment for 5 or more years. DRA results from the failure of the kidneys to filter and remove a protein called "beta-2 microglobulin," cause cysts across the body, from joints to internal organs. These cysts can be extremely painful, and sometimes fatal, for those with DRA. Although for years there was no treatment available in the United States, a treatment was approved in 2015. Unfortunately, the Medicare program does not cover the treatment, which is of great concern to me and my constituents.

In March of 2015 the FDA approved a new treatment for DRA using a special apheresis "column" in which blood is taken from the patient, processed to remove an accumulation of the bad protein (beta-2 microglobulin) and returned to the patient. Because the patient population is so small and the treatment was sufficiently safe, the FDA approved the treatment as a Humanitarian Use Device. Yet, despite being approved 6 years ago, I am told the Medicare program is still evaluating the appropriate coverage pathway for the treatment. Until Medicare reaches a decision, Medicare beneficiaries continue to be denied access to the only FDA approved treatment for DRA.

Can you commit to work expeditiously to apply an appropriate Medicare benefit category and finally decide coverage for this DRA treatment, and any other Humanitarian Use Devices approved by FDA but not yet covered by the Medicare program?

Answer. I agree that is it important for Medicare beneficiaries, particularly patients with complex medical conditions such as ESRD, to have access to medically necessary treatments. If confirmed, I am happy to look into this further and work with you on this issue.

HOSPICE

Question. The COVID–19 pandemic has brought telehealth to the forefront of care, dramatically increasing accessibility and making strides toward health equity. The hospice community has rapidly expanded its telehealth services for the entire Interdisciplinary Team, from nursing to chaplains. However, CMS does not appropriately capture telehealth claims and therefore lacks visibility into a critical aspect of hospice care delivery. The 2021 shift by CMS to only claims based hospice quality measurement, exacerbates this gap in essential care delivered. Creating telehealth codes for the entire hospice Interdisciplinary Team including the required chaplains' visits, would give CMS proper visibility into the hospice landscape.

Will CMS commit to implementing appropriate codes for hospice's telehealth services for every IDT discipline, including chaplain visits?

Answer. Improving the safety and quality of end-of-life care is important, and telehealth has been and continues to be an important tool during the pandemic. While often at end of life, hands-on care is needed to manage symptoms, sometimes telehealth may be an appropriate and safe way to receive hospice care. If I am fortunate enough to be confirmed, I look forward to learning more from you about this issue and working to ensure that hospice patients have access to the highest quality care.

MA PLAN TREATMENT OF NEW TECHNOLOGY IN ESRD

Question. As you know, Medicare Advantage plans are required to ensure coverage equal to that offered under fee-for-service. However, patient groups and other stakeholders have noted that Medicare Advantage plans may not have, or may not plan to, appropriately reimburse for End Stage Renal Disease (ESRD) drugs that are under the transitional drug add-on payment adjustment (TDAPA) through their negotiated monthly rates. Under certain circumstances this may just be a failing of timing, but what happens when new technologies appear after plans have already negotiated their rates? Failing to appropriately account for TDAPA payments puts a strain on dialysis organizations and hurts patient access to top of the line therapies. Additionally, many stakeholders continue to be concerned about the TDAPA "cliff." After 2 years of additional payment for these innovative therapies, drugs which fall into minimally funded categories represent undue financial pressure for providers when the transitional payment goes away. This cliff can result in providers having to make difficult choices about how to continue to provide innovative products to their patients.

While CMS does not interfere in direct negotiations between Medicare Advantage plans and their contracted providers, it does bear responsibility for upholding parity of coverage. How will CMS rectify this patient access issue?

Can you commit to patients that this and other over-arching issues with TDAPA will be something that you have CMS look at so that we can feel comfortable knowing that the sickest patients will have access to all of these innovative therapies in the pipeline?

Answer. It is important for Medicare beneficiaries with ESRD to have access to the ESRD therapies they need. Given that people with ESRD had the new option to enroll in Medicare Advantage plans for coverage beginning this year, Medicare Advantage now has a crucial role in providing access to ESRD therapies for Medicare beneficiaries. If confirmed, I will work to ensure that beneficiaries have access to ESRD therapies under Medicare Advantage plans. I will also work to ensure that Medicare beneficiaries continue to have access to innovative therapies and to improve patient outcomes.

GLOBAL AND PROFESSIONAL DIRECT CONTRACTING MODEL

Question. Recently CMS announced that it would not be allowing a second round of applications for the Global and Professional Direct Contracting Model. However based on multiple polls, letters to the agency, and media reports, there is a significant coalition of providers, including Baylor Scott and White in Texas, that were interested in participating in the second application cohort. Many providers apparently delayed participating in the program because of the pandemic.

What will you be doing to ensure that those providers are given an opportunity participate if they want to take on risk in the Global and Professional Direct Contracting Model and what are the administration's plans for this model and other models like it?

Answer. The Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't and chart a path forward from there. This absolutely includes getting stakeholder and congressional input. If confirmed, I will work with you to make sure we are pursuing models that recognize the strides providers have already made and improve our health-care system.

ALLINA RULING

Question. As CMS Administrator, would you respect the ruling of the Supreme Court in the *Allina* case with regard to calculating DSH payments by including Medicare Advantage enrollees inpatient days who are also eligible for Medicaid?

Answer. If confirmed, I will absolutely respect the Supreme Court rulings and follow the law.

CHILDREN'S HEALTH

Question. As CMS Administrator, you will oversee a number of programs and agencies important to children from health coverage programs vital to children's health such as Medicaid and the Children's Health Insurance Program (CHIP) to programs responsible for training the pediatric health-care workforce like the Children's Hospital Graduate Medical Education Program (CHGME) to pediatric research initiatives at the National Institutes of Health.

What are your priorities for child health, if confirmed?

Answer. Programs such as Medicaid and the Children's Health Insurance Program (CHIP) are critical programs that help ensure that children have adequate access to quality health care. If confirmed, I would work to ensure children are receiving necessary health care through both programs. I would also look to better ensure access to oral health and vision care for children, as both are necessary for children to thrive in school. And we cannot forget that improving child health begins with ensuring maternal health. I will work tirelessly to reduce maternal and infant mortality and morbidity, using the expertise and resources across CMS and working collaboratively with colleagues across HHS. I look forward to working with Congress, and with State and local partners to make sure that we are doing all we can to improve child health in this country.

Medicaid and CHIP are critical programs for children, providing coverage for over 40 million children. Medicaid is also the backbone of the pediatric health-care system providing care across the continuum from screenings and preventive to highly specialized diagnoses and treatments.

Question. What are your plans to strengthen this safety net for children and the providers who care for them?

Answer. If confirmed, I would work to support and strengthen Medicaid and CHIP to ensure that children have adequate access to quality health care. In particular, I would look to better ensure access to oral health and vision care for children, while working to reduce maternal and infant mortality and morbidity. If confirmed, I look forward to working with you to make sure our children have access to quality care.

The pandemic is having a profound impact on children's health and the providers who care for them.

Question. What are your immediate plans to address the current crisis in the increasing number of children facing severe mental, emotional and behavioral health challenges due to social isolation and the serious impact of the pandemic on the health of their families and caregivers?

Answer. I am deeply concerned about the impact of the COVID–19 pandemic on the mental, emotional, and other behavioral health outcomes of our children, their families and caregivers. I agree this must be an urgent national priority. If confirmed, I commit to working on this issue. In particular, we must ensure that we are fully leveraging Medicaid and CHIP to connect children to the behavioral health care they need to navigate this unprecedented time, and to work toward better integration of physical and behavioral health care. If confirmed, I would seek to collaborate with other HHS agencies, including SAMHSA, to do a better job of tackling this important issue.

Question. The pediatric health-care safety net has been affected by the pandemic in different ways then the adult health-care system, with less direct Federal financial support because they are not eligible for Medicare funding streams. What are your plans to sustain a stable pediatric health-care system now and beyond the pandemic?

Answer. Medicaid and CHIP are lifelines to children and help form the fabric of the pediatric health-care safety net. Over 77 million individuals are enrolled in those programs, and about half are children. It is critical that we work to support our pediatric health-care safety net and pediatric health-care providers during the COVID–19 pandemic and beyond. If confirmed, I would make it a priority to work within CMS and with my HHS partners and State Medicaid agencies, to provide necessary support to pediatric providers.

Question. The Children's Hospital Graduate Medical Education Program (CHGME) provides significant support for the training of pediatricians and pediatric specialists. But unfortunately, the funding for this program still lags far behind the Medicare GME program—funding only half of what Medicare GME provides per resident.

What are your plans to address this gap in training support for our Nation's pediatric workforce?

Answer. If confirmed, I will work with the resources within CMS and partner with State Medicaid agencies to support the health-care workforce, including those who work with pediatric populations. I would look forward to working with HHS partners as well, including HRSA, on ensuring access to needed health care for our Nation's children.

Question. During the pandemic telehealth has played a major role in providing access to care for Medicaid beneficiaries, including children.

How will HHS support the continued use and enhancements needed under Medicaid to ensure telehealth continues to enable access to care for children?

Answer. Telehealth is an important tool to improve health equity and improve access to health care. Health care should be accessible, no matter where you live. Under current law, States have a great deal of flexibility with respect to delivering Medicaid services via telehealth. Medicaid has made great strides in expanding services available through telehealth, including pediatric services, during the public health emergency. If confirmed, I will look at the telehealth flexibilities under Medicaid and determine how we can build on this work to improve health equity and improve access to health care for children.

Question. As you know, pediatric health care is organized differently than adult health care. Pediatric care is more regionalized and often results in children, especially those with complex health needs, having to travel across State lines for care. Under Medicaid, this can be challenging for them and their providers with different policies State to State. The ACE Kids Act passed in 2019 and is effective next year, is one step in addressing these inconsistencies and getting much needed national data to inform care improvements.

If confirmed, how would you approach these cross-State challenges that children with complex needs face when traveling for needed care?

Answer. Medicaid and CHIP are crucial to ensuring children have adequate access to quality health care, especially those with complex needs. If confirmed, I will work to ensure children are receiving necessary health care under both Medicaid and CHIP. I look forward to working across the administration and with Congress to make informed decisions that address the specific needs of children with complex medical conditions.

Question. 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. At times, Medicare policies designed with the elderly population in mind have been applied to Medicaid or adopted by State Medicaid programs and private payers.

As you look at health-care changes at the national level as HHS Secretary, how will you ensure that children's unique health-care needs are taken into account?

Answer. If confirmed, I will work with Congress and States to spur and encourage innovation in these important programs. Innovative delivery system and payment models are vital to ensuring that Medicaid and CHIP are equipped to address

emerging pediatric health issues and can continue to provide children with access to quality health care.

Question. A major focus in health care among policy-makers has been on pursuing delivery system reforms that improve quality and reduce costs. The Federal Government has traditionally focused more on adult populations rather than the needs of children in these reforms. As a result, Medicaid for children still lags behind Medicare in supporting improvements in care and innovative payment models.

What steps will you take to promote increased emphasis on these types of innovations in Medicaid targeting the unique needs of children?

Answer. If confirmed, I will work with Congress and States to spur and encourage innovation in these important programs. Innovative delivery system and payment models are vital to ensuring that Medicaid and CHIP are equipped to address emerging pediatric health issues and can continue to provide children with access to quality health care.

FOLLOW-UP QUESTIONS FOR THE RECORD

Question. Recently, CMS announced it was withdrawing the 10-year renewal of Texas's 1115 Medicaid waiver. The State negotiated intensively and in good faith with CMS to achieve approval of the renewal.

If confirmed, how will you advise CMS to view the previous agreement reached on the budget neutrality calculation which impacts the amount of Federal Medicaid funding the State can expect to receive?

Answer. Based on my experience working with many State officials throughout my career, I appreciate what is required for States to develop and submit waiver applications to CMS for consideration and approval. Additionally, I understand the challenges many States face in formulating waiver requests given their distinct budgetary processes and legislative calendars. With this in mind, if I am fortunate enough to be confirmed, I will make sure that CMS provides clear guidance and works closely with each State, including Texas, on its ideas to innovate in the Medicaid program.

Question. The waiver recession would prevent billions of dollars from flowing to Texans in need and would threaten numerous aspects of Texas's health-care system, given Texas's reliance for months on the extension approval. This could begin having dramatic impacts on Texas as soon as September.

If confirmed, will you work with Texas to ensure that the State can continue to provide safety-net programs notwithstanding the unique challenges that the State faces?

Answer. If I am fortunate enough to be confirmed, I will be happy to work with you and State officials in Texas on this issue.

Question. The decision to rescind the extension comes at a time when the Biden-Harris administration continues to urge that COVID–19 is a public health emergency.

How do you reconcile an action undermining the health care of many needy Texans with the urgency of COVID–19, and if confirmed, what steps would you take to provide Texans facing potential funding losses with the care needed in light of COVID–19?

Answer. While I am not an official at CMS, it is my understanding that this extension was rescinded because the agency determined that the appropriate notice and public comment requirements were not met. I appreciate Congress's leadership in making sure that patients suffering from COVID–19 have been able to get the care they need during the public health emergency, and if I am fortunate enough to be confirmed, I would look forward to working with you on this issue.

Question. The letter purporting to rescind the extension would effectively overturn a discretionary decision by the former Secretary, on which Texas relied for months in planning and implementing health-care programs. This causes serious concern for Texas and other States considering whether they can rely on these types of discretionary decisions.

If confirmed, what steps will you take to restore trust with States that are relying on such decisions in structuring their health-care systems?

Answer. I have worked closely with States throughout my career, and I understand the relationship with CMS as States' Federal partner is crucial. If confirmed, I will keep in mind what I have learned working on behalf of States to make sure waiver requests are appropriately evaluated while giving the States clear guidance.

Question. It has been reported that waivers like Texas's that support uncompensated care pools are viewed as a roadblock to Medicaid expansion, and that they run counter to the Biden administration push for States to expand.

Do you believe Medicaid expansion is the only way for States to provide care for uninsured individuals?

If not, what other options are being considered by the administration?

Answer. I support State innovation and the ability of States to test different models that meet the objectives of the Medicaid program. No two Medicaid programs are exactly alike, just like no two States are alike. If I am so fortunate as to be confirmed, I look forward to engaging with any State that seeks to meet their population's unique needs, including those of the most vulnerable.

Question. It has also been reported that the decision to rescind the waiver was done to push State officials to accept Medicaid expansion.[1]

Do you believe the 1115 waiver extension was rescinded in order to force Texas to expand their Medicaid program?

Answer. It is my understanding that this extension was rescinded because CMS determined that the appropriate notice and public comment requirements were not met. If I am fortunate enough to be confirmed, I look forward to working with you and State officials in Texas if the State decides to resubmit a section 1115 demonstration extension application.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

CMS–FDA COORDINATION

Question. I often hear from constituents about the reluctance of the Medicare program to cover new and innovative therapies. Even as the commercial market recognizes the benefits of breakthrough technologies and medicines, the Medicare program lags behind in covering novel products that can save and improve lives.

A recent CBO report on pharmaceutical R&D provided a stark reminder of just how difficult it is to develop these new medicines. The costs of bringing a new drug to market have been estimated to top $2 billion.[2] Given this immense cost, the Federal Government should ensure a clear pathway to coverage for companies that work to meet the FDA's gold standard of safety and efficacy and bring new treatments to patients.

If confirmed, you will lead the agency at a time when innovative therapies and technologies are changing the way care is delivered. To meet this moment, Medicare must also adapt. I have long been a proponent of increasing the coordination between CMS and FDA to ensure that our Federal health programs—and the Americans that rely on them—are prepared for the upcoming pipeline of novel technologies.

Will you commit to working with my office to further the goal of enhanced coordination between CMS and FDA to bring innovative medical products to Americans in as timely a manner as possible?

If so, what are some of the ways in which CMS could work with FDA in order to reduce the time patients wait for new treatments and therapies?

Currently, there is a therapy under review at FDA that, if approved, would be indicated for the treatment of Alzheimer's disease—a uniquely devastating illness in terms of its breadth and lethality. The action date for this therapy under the Prescription Drug User Fee Act is June 7, 2021. To date, FDA has only approved one

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[1] "The decision was characterized as an effort to push State officials toward accepting the Affordable Care Act's Medicaid expansion, which would cover more low-income residents, said two Federal health officials, who spoke on the condition of anonymity to discuss private conversations." *https://www.washingtonpost.com/health/2021/04/16/biden-rejects-texas-medicaid-plan/*.

[2] *https://www.cbo.gov/system/files/2021-04/57025-Rx-RnD.pdf.*

method of diagnosis for Alzheimer's disease—a PET scan. CMS has denied Medicare coverage of PET scans for Alzheimer's pathologies, however. If this therapy is approved, Medicare's decision to forego coverage of this diagnostic could present a barrier to access for patients with no other effective therapeutic options. This specific situation is just one that demonstrates the broader need for FDA and CMS coordination. Will you commit to working with me on ensuring appropriate Medicare coverage of PET scans and other diagnostics that may benefit patients with Alzheimer's disease?

Answer. Thank you for your leadership on the issue of expanding access to the benefits of innovative medical technologies to American patients and families. It is incredible what science has been able to do with innovative drugs and treatments in recent years. We need to make sure we're looking at modernizing the Medicare program to make sure beneficiaries have access to proven new treatments. I also think it is important for CMS to be collaborating with other agencies, including the FDA, to make sure we work better together. If I have the honor of being confirmed, I would be happy to work with you on this important issue.

Question. In 2019, now-Acting FDA Commissioner Janet Woodcock testified before the House Energy and Commerce Committee that advanced manufacturing technologies could enable domestic drug producers to compete with China's lower labor, supply, and operating costs.[3]

How can the programs administered by CMS play a role in strengthening the security of supply chains, both broadly and for specific fields, like synthetic biology?

Do you agree that if CMS is to play a role in addressing supply chain issues that it needs to coordinate with FDA to better understand the nuance and complexities of global supply chains?

Answer. America continues to be a leader in medical innovation. This has been crucial during the pandemic. I agree that the Nation's supply chain must be secure. If confirmed, I will make sure CMS is a helpful partner to FDA in this effort.

HI TRUST FUND

Question. Medicare Part A has a longstanding insolvency problem. The Hospital Insurance (HI) Trust Fund that finances Part A is funded by payroll taxes and as program spending has outpaced payroll tax revenues, the balance of the trust fund has steadily declined. In February, the Congressional Budget Office (CBO) projected that the HI Trust Fund will run out of money by 2026. CBO also estimates that expenditures will continue to outpace payroll tax revenue after the trust fund has been depleted.

Addressing Medicare's finances sooner rather than later would allow for subtle, gradual changes that protect seniors' access to high-quality care while ensuring sustainability for future generations. The alternative would threaten sudden and steep benefit cuts for tens of millions of senior citizens.

As Administrator of CMS, if confirmed, you will be looked to by the President and Congress for leadership and assistance on reform proposals small and large. What specific experience do you have in crafting or evaluating proposals to reform the Medicare program?

Answer. Medicare solvency is an incredibly important, longstanding issue. We will need both short-term and long-term strategies to make sure Medicare remains a bedrock of our health-care system, and I look forward to working with Congress on a bipartisan basis to address this. I look forward to working with you on ways to improve the solvency of the Medicare program.

PRICE TRANSPARENCY

Question. Empowering consumers with health-care price information so they can make informed health-care decisions has long been a bipartisan priority. If confirmed as Administrator, are you committed to ensuring full implementation of the Transparency in Coverage final rule?

Answer. I agree that empowering consumers with health-care price information is important. For transparency measures to work properly, patients and their fami-

[3] *https://www.fda.gov/news-events/congressional-testimony/safeguarding-pharmaceutical-supply-chains-global-economy-10302019.*

lies must be able to understand them in a meaningful way. If I am fortunate enough to be confirmed, I look forward to continuing to work on this issue.

FOSTER CARE

Question. The Family First Prevention Services Act created a new Federal category for settings that deliver trauma-informed treatment for foster children with serious emotional or behavioral issues in a residential setting, known as Qualified Residential Treatment Programs (QRTPs). QRTPs are one of the few residential settings that are eligible for title IV–E reimbursement. Recently, however, the Centers for Medicare and Medicaid Services (CMS) indicated QRTPs with more than 16 beds may meet the definition of an Institutions for Mental Diseases (IMDs), preventing Medicaid reimbursement for care in these circumstances. This interpretation is not consistent with congressional intent.

Do you believe that QRTPs should be exempted from the IMD payment exclusion, allowing children in foster care to have Medicaid coverage in these placements?

Answer. This is an important and complex question that I am committed to addressing if I am confirmed as CMS Administrator. I share your conviction that children in foster care should receive necessary medical care without disruption. If I am fortunate enough to be confirmed, I will be happy to work with you on this critical issue.

MACPAC PROPOSAL

Question. As you know, the statutory Medicaid Drug Rebate Program (MDRP) requires drug manufacturers to provide rebates on drugs to State Medicaid programs rebates to ensure Medicaid receives the lowest price relative to private payers. There is an additional mandatory rebate on drugs calculated according to increases in price that exceed inflation. Earlier this month, the Congressional Budget Office cited research showing that the MDRP contributes to higher prices paid by private payers, as offering additional discounts in the private markets would result in lower Medicaid revenues.[4]

The Medicaid and Chip Payment and Access Commission (MACPAC) recently voted on recommendations to increase the amount of rebates manufacturers must pay for drugs brought to market under the accelerated approval pathway at FDA.

Do you think this recommendation is appropriate?

If so, what are your reasons for supporting this unprecedented approach to tying rebates to FDA approval pathways?

MACPAC has acknowledged that this policy could create access issues for the Medicaid population. How would you ensure equitable access to these treatments and therapies if this policy were to be adopted?

Answer. We can all agree that prescription drug costs are too high for American patients and families. From my many meetings with Senators in the last few weeks, I have seen that addressing this is a priority on both sides of the aisle. I think there is an opportunity for real impact here to lower costs for American patients and families, while making sure to continue to support innovation.

Prescription drug costs, including in the Medicaid program, are very complex. Ultimately, we need solutions that produce real results to bring down overall costs for American patients and families while avoiding barriers to access. I would be happy to examine this particular MACPAC proposal in more detail. If confirmed, I look forward to working with you and your colleagues to find solutions to the high cost of prescription drugs without reducing access to necessary treatments.

CLINICAL TRIALS

Question. Late last year, the Clinical Treatment Act, was signed into law. Senator Cardin and I crafted this legislation to ensure Medicaid beneficiaries have access to clinical trials by requiring State Medicaid programs to provide coverage of routine medical care associated with the trial—a benefit already provided by Medicare. This law will improve access to potentially life-saving therapies for sick Americans as well as broaden the base of clinical trial participants, which will improve the ability of manufacturers to conduct these trials.

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[4] *https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.*

How will you ensure that this important benefit is available to Medicaid beneficiaries as expeditiously as possible?

Answer. If I am fortunate enough to be confirmed, I will work with the National Institutes of Health and with trusted partners in the community to help to encourage participation in clinical trials, which—as you noted—can offer potentially lifesaving treatment opportunities to patients. One barrier to participation in these trials can be payment for routine medical care associated with the trial, so I think it is so important that Medicaid will pay for covered items and services provided as part of qualifying clinical trials starting January 1, 2022. If confirmed, I would look forward to working with you, Senator Cardin and other members of Congress on this issue as we work to implement this important benefit in a timely manner.

CMMI

Question. The Patient Protection and Affordable Care Act (PPACA) created the Centers for Medicare and Medicaid Innovation (CMMI) and afforded it broad authority to test new payment models. The law requires the termination or modification of any model that does not improve quality of care without increasing spending; reduce spending without reducing quality of care; or improve quality of care while also reducing spending. Shockingly, the PPACA also included a clause attempting to block any administrative or judicial review of CMMI demonstration models, leaving the Administrator as a key, potentially unaccountable, arbiter of whether or not the law's requirements are being followed.

How specifically will you ensure that statutory requirements for CMMI models are stringently adhered to? Will you commit to working with members of this committee to establishing a permanent mechanism for congressional input and oversight?

Answer. The Innovation Center has been an important tool to test new models to move our health-care system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't and chart a path forward from there. If I am fortunate enough to be confirmed, I want to have open lines of communication with Congress, and I look forward to hearing from you about CMMI models.

CLINICAL LABORATORY FEE SCHEDULE

Question. The Medicare Clinical Lab Fee Schedule (CLFS) payment rates for antigen testing that use visual interpretation for results have traditionally been the same as the tests that utilize instruments to interpret results. However, CMS has recently changed this practice for COVID–19 testing, bifurcating the rates for these types of tests. This bifurcation occurred in June 2020.

Why does CMS believe that a bifurcation in reimbursement rates was warranted in the case of SARS–CoV–2 antigen testing?

Under your leadership, how would CMS incentivize the development of digital health technologies that make diagnostic test results accurate and reliable?

Answer. Access to safe and reliable testing is key to combating the COVID–19 pandemic. If I am fortunate enough to be confirmed, I look forward to hearing from you about Medicare's clinical laboratory fee schedule rates and protecting beneficiary access to laboratory testing services, including digital technologies where appropriate.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. As part of the American Rescue Plan Act (ARPA; Pub. L. 117–2), approximately $35 billion is estimated to be spent to temporarily expand Obamacare subsidies to current marketplace enrollees and individuals making over 400 percent of the Federal poverty level, including high-income earners or those making over six-figure salaries. The majority of these subsidies will go to individuals who already have health insurance. Furthermore, taxpayers are expected to spend an additional $6 billion to temporarily pause premium tax credit reconciliation for plan year 2020—meaning individuals who received more than they should *will not* be asked by the Federal Government to repay taxpayers for those improper subsidies. In the past, multiple government watchdogs have concluded that these taxpayer subsidies

are susceptible to significant improper payments. As the Federal deficit hits records highs, more must be done to ensure our taxpayer dollars are spent wisely.

You have extensive programmatic experience with the Federal marketplace and Virginia's State marketplace. If confirmed, how will you work with the Internal Revenue Service to reduce the advance premium tax credit program's susceptibility to improper payments? Please be specific.

Answer. Advance payments of premium tax credits have helped make health insurance more affordable for millions of Americans and improved their access to care. This has been especially important during the pandemic when access to affordable health care has been more critical than ever. If confirmed, I will take seriously these responsibilities, including working with the Internal Revenue Service to make sure that we are good stewards of Federal dollars.

Question. Over the years, the Medicare improper payment rate has dropped well below 10 percent. In fact, the improper payment rate for FY2020 dropped to 6.27 percent from 7.25 percent in FY 2019—its lowest rate in more than a decade. Further, over the past decade, the Medicare Advantage and Part D improper payment rates at their highest reached 11 percent and 3.7 percent respectively. In FY2020, the Medicare Advantage and Part D improper payment rates dropped to 6.78 percent and 1.15 percent respectively. Unlike the Medicare program, however, the Medicaid improper payment rate has ballooned. Most recently, the national improper payment rate in Medicaid was 21.36 percent, or $86.49 billion. Not only has the Medicaid improper payment rate doubled since 2010, but it is now more than triple the improper payment rate of the Medicare program.

If confirmed, what actions will you take to bring the improper payment rate in the Medicaid program under 10 percent? Please be specific.

Answer. Medicaid is a critical lifeline for beneficiaries across the country. Reducing Medicaid improper payments is a priority because it helps ensure the fiscal health of the program. If confirmed, I will work with States and leaders in Congress to be responsible stewards of taxpayer dollars.

Question. Last fall, Senator Stabenow and I sent the Department of Health and Human Services a detailed letter recommending specific regulatory actions to improve our Federal health-care programs for beneficiaries with Alzheimer's disease. These recommendations were formed with input from more than 30 organizations that responded to a request for information as well as hearings and briefings led by Senator Stabenow and myself. Recently, the Biden administration took action on one of our recommendations and finalized a centralized website for patients and their caregivers to access information regarding their care options and clinical trial enrollment. However, other recommendations remain unimplemented.

If confirmed, how will you help increase access to innovative diagnostic tools and/or make improvements to existing methods of assessing cognitive impairment, such as direct observation, in the Medicare program to improve early detection of Alzheimer's disease? Additionally, with the potential for the first disease modifying drug to be approved by the U.S. Food and Drug Administration, existing tools like the amyloid PET scan are the only option for confirmatory diagnosis until a non-invasive, affordable, and rapid diagnostic tool, such as a blood test, is made available to the public. Coverage determinations play a large role in diagnosing, treating, connecting to wrap-around services, and clinical trial enrollment. If confirmed, will you examine existing CMS coverage policies to ensure the Medicare program provides seamless access to the best diagnostic tool(s) available to this patient population and other similarly situated disease groups?

How can the Medicare Advantage program play a role in strengthening care coordination among this population?

What other policies will you prioritize to improve the lives of Medicare and Medicaid beneficiaries living with Alzheimer's disease?

Answer. Alzheimer's disease is a devastating condition for patients and families. Early detection is critical to improve care, and I agree that CMS should work to improve coverage of proven diagnostics. I also agree that better coordinating healthcare benefits patients, and we should strive to improve care coordination across programs. Medicaid and Medicare, including Medicare Advantage, have an important role to play in providing this type of quality care, including to those living with complex conditions like Alzheimer's disease. I would be happy to work with you on this important issue should I be confirmed.

Question. Through section 1115 waiver authority, State Medicaid programs can waive certain programmatic requirements to implement greater flexibilities with their eligibility, benefit, and delivery systems. CMS plays an instrumental role in the implementation of section 1115 waivers through the negotiation process and oversight of their financial performance.

If confirmed, how would you work to uphold and enforce the longstanding policy of budget-neutrality for section 1115 waivers and ensure the integrity of their financial performance?

Answer. Each State is unique, and innovation is critical to improving the health-care system. Section 1115 demonstration projects, or waivers, are one available tool to States to help test new and innovative policies in Medicaid. I agree that it is important that we are good stewards of taxpayer dollars while pursuing innovation. If confirmed, I will support State innovation and the ability of States to test out different models that meet the objectives of the Medicaid program.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

ON LEVERAGING VIRTUAL HEALTH TECHNOLOGY AND TELEHEALTH TO EXPAND ACCESS TO CARE

On Enhancing Telehealth Access

Question. Earlier this Congress, joined by Senator Schatz and a bipartisan group of my Senate colleagues, I introduced the Telehealth Modernization Act, legislation aimed at increasing access to high-quality health-care services, particularly for our Nation's seniors, by codifying crucial flexibilities for telehealth coverage.

Long before the pandemic began, South Carolina had emerged as a leader in telehealth innovation, hosting one of just two federally recognized Telehealth Centers of Excellence in the Nation. High-quality telehealth services and networks spearheaded by cutting-edge providers like the Medical University of South Carolina have transformed the Palmetto State's health-care landscape. Unfortunately, however, for the majority of the State's roughly 1 million Medicare beneficiaries, outdated coverage restrictions have long inhibited access to telehealth services.

For years, rigid rules around patient location (geographic and site of service), eligible services and provider sites, and other components of care have created substantial barriers to telehealth utilization. In February 2020, for instance, just prior to the COVID–19 public health emergency (PHE), only 0.1 percent of Medicare fee-for-service (FFS) primary care visits were delivered via telehealth. In any given week before the PHE, an average of just 14,000 Medicare beneficiaries received a telehealth service.

Congress took decisive steps towards expanding telehealth access through the CHRONIC Care Act, particularly for the roughly 36 percent of Medicare beneficiaries nationwide who have chosen to enroll in Medicare Advantage (MA) plans, more than three-quarters of which provided extra telehealth benefits, even before the pandemic struck. For South Carolina, however, MA penetration remained below 30 percent last year. For the 72 percent of SC's Medicare beneficiaries enrolled in FFS coverage, substantial restrictions have remained.

While these Medicare access gaps predated the pandemic, the spread of COVID–19 highlighted the urgency of updating telehealth coverage rules, prompting Congress to provide authority for pivotal emergency waivers designed to ensure safe access to care for seniors and other vulnerable populations. As the pandemic raged, Medicare beneficiaries turned to telehealth services to minimize viral exposure risk and receive medically necessary care in safe and accessible settings. In April 2020, more than two-fifths (43.5 percent) of Medicare FFS primary care visits were provided through telehealth, and from mid-March through early July of that year, more than 10.1 million beneficiaries accessed telehealth services.

Without congressional action, however, these emergency flexibilities will expire at the end of the PHE, creating an access cliff for tens of millions of Medicare beneficiaries, including many who have come to rely on telehealth for critically needed care.

If confirmed, can you commit to making the expansion of telehealth access, particularly for seniors and vulnerable populations, a priority for the Centers for Medicare and Medicaid Services (CMS)?

The Telehealth Modernization Act would eliminate a number of outdated restrictions on Medicare coverage for telehealth services, including by removing geographic and originating site restrictions and ensuring that federally qualified health centers and rural health clinics can continue to serve as distant sites, even after the pandemic subsides. Would you support these types of policy proposals as a means of expanding access to care?

Can you commit, if confirmed, to working with my office, Sen. Schatz's office, and the offices of other telehealth access supporters to ensure that the tens of millions of Medicare beneficiaries enrolled in FFS do not face a coverage cliff when the public health emergency expires?

In the absence of the emergency waivers, what would you cite as some of the most significant barriers to telehealth access, particularly for seniors and those with serious health conditions, and what steps would you take as CMS Administrator, if confirmed, to address some of these barriers?

What role or roles do you see telehealth and other virtual health technologies in playing within the administration's broader goal of combating health disparities?

I see our digital infrastructure as a powerful tool in addressing health disparities. If confirmed, how would you work with other Federal agencies and officials to bolster broadband access and bridge the digital divide?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers, and their families safe. My brother is a psychologist, and telehealth has helped his patients get the care they need. Additionally, I agree that telehealth services have improved health equity as beneficiaries have used telehealth to access care during the COVID–19 pandemic. Broadband access is a challenge for many patients, however, and I agree that digital infrastructure is an important issue to consider in the context of addressing health disparities. If confirmed, I want to be sure we learn lessons from this pandemic on telehealth about what we can and should extend administratively and what will need congressional action.

On Improving the Medicare Diabetes Prevention Program (MDPP) Expanded Model

Question. The Medicare Diabetes Prevention Program (MDPP) Expanded Model (EM) leverages proven interventions to prevent the onset of type 2 diabetes in Medicare beneficiaries with prediabetes. In 2016, the Chief Actuary of CMS certified that "beneficiaries participating in diabetes prevention programs have achieved success with losing weight and reducing the incidence of diabetes" and that the expansion was "expected to reduce Medicare expenditures." According to CMS, the program at the core of the expanded model "has been shown to reduce the incidence of diabetes by 71 percent in persons age 60 years or older."

Unfortunately, the exclusion of innovative virtual suppliers from the MDPP EM has impeded the program's reach and created substantial access gaps, particularly for older Americans living in rural and underserved urban communities. *Politico* reported that only 202 beneficiaries had used the program in 2018, and an *American Journal of Managed Care* study published in June 2020 concluded that "inadequate MDPP access" stemmed in part from "severe shortages" of suppliers, particularly in States with large populations of Medicare beneficiaries of color. The COVID–19 pandemic has highlighted and exacerbated these access barriers, but regulatory flexibilities remain limited.

In order to address these access gaps, last Congress, I partnered with Senator Warner in leading a number of letters to HHS and CMS leaders, urging them to take administrative action to enable the participation of CDC-recognized virtual suppliers in the MDPP EM. We also introduced the bipartisan, bicameral PREVENT DIABETES Act, which would accomplish the same goal legislatively. Unfortunately, virtual suppliers remain excluded from the program, and even the flexibilities provided for the pandemic emergency period have proven unable to improve access for beneficiaries in need.

The Biden administration has cited combating health disparities as a key policy priority. According to the CDC, 13 percent of American adults have diabetes, including 26.8 percent of those aged 65 or older. Diabetes prevalence varies substantially by race/ethnicity, affecting 16.4 percent of black adults, 14.9 percent of Asian adults, and 14.7 percent of Hispanic adults, versus 11.9 percent of white adults. A 2018 study that focused specifically on the provision of DPP services through virtual providers found statistically significant evidence of reduced costs and utilization pattern changes for a Medicare population, suggesting that the inclusion of virtual suppliers in MDPP, among other actions to strengthen the program, could help to ad-

dress disparities, reduce costs, and improve outcomes for older Americans across the board.

If confirmed, can you commit to working, in consultation with my office, Senator Warner's office, and other policy-makers, to enhance access to the Medicare Diabetes Prevention Program?

Can you commit to reviewing the robust evidence base and giving due consideration to the bipartisan and bicameral requests that I have led, in partnership with Senator Warner and others, to secure the inclusion of CDC-recognized virtual suppliers in the MDPP EM?

Beyond the MDPP EM, how do you envision CMMI's role in terms of facilitating the demonstration and evaluation of virtual care solutions and digital health tools?

More broadly, can you speak to the administration's efforts to enable Medicare beneficiaries to leverage digital health tools for the prevention and treatment of disease? Are their limitations in your ability to expand access to these valuable resources for those that want to use them within Medicare?

Answer. The Medicare Diabetes Prevention Program is an important model, and I appreciate your leadership in supporting patients with diabetes. I absolutely want to look at all options to help prevent diabetes, and I look forward to hearing more from you, Senator Warner, and other members of Congress on ways we can improve the program for Medicare beneficiaries.

The Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and chart a path forward from there. I look forward to hearing more of your thoughts on the direction of CMMI.

ON ENHANCING ACCESS TO INNOVATION

Question. As co-chair of the bipartisan, bicameral Personalized Medicine Caucus, I have long championed the potential for cutting-edge innovations like gene and cell therapies to transform the treatment landscape. In recent years, the pace of development on these fronts has accelerated, with a report from last Spring suggesting that more than 360 gene and cell therapies were in the United States' clinical pipeline, versus fewer than 300 just 2 years earlier. More than one-third of these therapies aim to treat rare diseases, providing cause for optimism to patients across the country, as 95 percent of the 7,000 known rare diseases currently lack an FDA-approved treatment option. Individuals with sickle cell disease, for instance, which affects an estimated 100,000 Americans, could feasibly see a cure on the horizon.

According to a 2019 statement by key FDA leaders, the agency anticipated, at that point, approving 10 to 20 new gene and cell therapies every year by 2025, in addition to receiving a projected 200 investigational new drug applications for gene and cell therapy candidates annually, beginning in 2020.

I appreciate the emphasis that you placed, in your testimony, on advancing innovation.

That said, even in the face of these potentially lifesaving developments, hurdles remain, even for gene and cell therapies that successfully gain FDA approval. A number of laws and regulations around Medicaid "best price," the Anti-Kickback Statute (AKS), and the Stark Law, among other relevant statutes, understandably failed to contemplate this new generation of gene and cell therapies, which have only recently begun to come to market.

A disproportionate share of the patients affected by the diseases most likely to be treated by the early waves of gene and cell therapies receive health-care coverage through Medicare or Medicaid. With that in mind, would you agree that HHS should do all that it can to ensure access to FDA-approved cell and gene therapies when a doctor and a patient agree that it is the most appropriate treatment option?

The current Medicaid reimbursement structure was not designed with curative therapy payments in mind. For the roughly 100,000 Americans affected by SCD and other painful and debilitating conditions, these outdated rules risk delaying patient access and hinder Medicaid's ability to pay for innovative therapies based on their value. How will HHS overcome barriers in the current Medicaid reimbursement

structure for cell and gene therapies, giving patients access to cures and not just treatments?

In December, HHS finalized the "Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements (CMS 2482–F)" rule, which took important steps towards ensuring that State Medicaid programs have the flexibility they need to hold manufacturers accountable for the performance of their therapies. Will CMS commit to implementing the VBP components of this rule and ensuring that patients have timely access to lifesaving cell and gene therapies?

If and when CMS implements this rule, barriers to value-based arrangements will remain, both within the Federal health-care programs and in the private sector. Can you commit, if confirmed, to working with my office to develop the additional legislative and regulatory solutions needed to facilitate meaningful value-based arrangements for drugs, biologics, devices, and other innovative medical products?

The prior administration issued new AKS safe harbors to protect value-based arrangements among health-care providers and other industry stakeholders, but value-based arrangements for drugs and biologics received no such protections, inhibiting the development of these types of agreements and jeopardizing patient access to innovation. Will you commit to developing a safe harbor that would help promote greater innovation in the pricing of drugs and biologics?

Generally speaking, what changes do you envision to CMS's policies that would promote the development of curative medicines to ensure that they are available to Americans as soon as possible?

With respect to sickle cell disease (SCD) in particular, can you commit to making efforts to combat SCD, both through novel gene therapies and through other innovative treatments and care models, a priority for CMS?

While surveillance data on the SCD patient population remains limited in many ways, research suggests that the majority of individuals affected by SCD may receive health-care coverage through Medicaid, giving CMS an especially significant role in ensuring access to care for these Americans. Would you be willing to consider pilot programs, demonstration projects, or other innovative models to drive care improvement for those affected by SCD?

Answer. It is incredible what scientific progress has been made with innovative drugs and treatments in recent years. We need to make sure we are looking at modernizing the Medicare and Medicaid programs to foster innovation and to make sure beneficiaries have access to proven new treatments. Thank you for your leadership on Sickle Cell Disease.

If confirmed, I look forward to working with you and other members to find solutions to improve treatments, care models, and access to new therapies, including for Sickle Cell Disease.

Question. FDA has testified "that advanced manufacturing technologies could enable U.S.-based pharmaceutical manufacturing to regain its competitiveness with China."

How can CMS leverage and advance the U.S. advantage in synthetic biology to solidify our domestic drug supply chain security?

Answer. America continues to be a leader in medical innovation. This has been crucial during the pandemic. I agree that the Nation's supply chain must be secure. If confirmed, I will make sure CMS is a helpful partner to the FDA in this effort.

On Coverage and Payment for Products Approved via Accelerated Approval

Question. As described by FDA, the Accelerated Approval Program "allow[s] for earlier approval of drugs that treat serious conditions, and that fill an unmet medical need based on a surrogate endpoint," meaning "a marker, such as a laboratory measurement, radiographic image, physical sign or other measure that is thought to predict clinical benefit, but is not itself a measure of clinical benefit." Furthermore, as explained by the agency, "[t]he FDA bases its decision on whether to accept the proposed surrogate or intermediate clinical endpoint on the *scientific support* for that endpoint" (*emphasis* mine).

In explaining the rationale for the creation of Accelerated Approval, FDA has noted that the use of intermediate or surrogate endpoints "can save valuable time in the drug approval process." In the example of cancer survival, for instance, the

agency points out that measuring the extension of survival for cancer patients could take many years, whereas trials can assess tumor shrinkage, which is reasonably likely to predict the desired endpoint, much more efficiently. In this broad example, the use of accelerated approval could result in patient access to a life-saving product literally years earlier than might have been possible otherwise. For countless Americans, from children suffering from debilitating cancers to adults afflicted by rare blood disorders, access to drugs and biologics cleared through the Accelerated Approval pathway have been the difference between life and death.

As we look towards the months and years ahead, scores of patients can look to Accelerated Approval and other innovative, evidence-based pathways as a source of hope, recognizing that a new generation of game-changing therapeutics could feasibly cure conditions like sickle cell disease.

In 2018, CMS wrote to States affirming that drugs approved via the Accelerated Approval pathway "must be covered by State Medicaid programs, if the drug meets the definition of 'covered outpatient drug,' noting that said products "must meet the same statutory evidentiary standards for safety and effectiveness as those granted traditional approvals." Can you commit to ensuring, if confirmed, that every State Medicaid program covers all covered outpatient drugs approved via the Accelerated Approval Program, with no difference in treatment between these products and products approved via the traditional approval pathway?

Despite substantial pushback from patient advocates and policymakers, the Medicaid and CHIP Payment and Access Commission (MACPAC) has moved to advance a proposal that would create a differential rebate structure for products approved via the Accelerated Approval Program, essentially penalizing drugs and biologics for moving to market and serving patients more quickly. In addition to disincentivizing the use of the Accelerated Approval pathway and thus denying scores of Americans, including many childhood cancer patients, with timely access to potentially life-saving medications, this policy risks deterring, chilling, or otherwise redirecting investment in products that do not lend themselves to efficient trials with easily and expeditiously measured primary endpoints. Moreover, the framing of the proposal itself suggests a misunderstanding of the scientific integrity and underlying purpose of the Accelerated Approval Program. Before advocating for or otherwise seeking to advance any policy proposals that might weaken, penalize, or otherwise chill the use of the Accelerated Approval Program, can you commit to engaging with FDA officials and experts, patient advocates, manufacturers, policymakers on the Hill, and other relevant stakeholders to assess the potential consequences of such policies?

Regardless of the administration in question, critics have often argued that FDA and CMS could and should work more collaboratively to ensure that safe and effective products can come to market as efficiently as possible. Can you commit to working with your counterparts at FDA to bolster collaboration and communication between the two agencies?

Answer. Thank you for your leadership on the issue of expanding access to the benefits of innovative medical technologies to American patients and families. It is incredible what scientific progress has been made with innovative drugs and treatments in recent years. We need to make sure we're looking at modernizing the Medicare and Medicaid programs to make sure beneficiaries have access to proven new treatments. I also think it is important for CMS to be collaborating with other agencies, including the FDA, to make sure we are working together to serve patients. I would be happy to examine this particular MACPAC proposal in more detail. If confirmed, I look forward to working with you and your colleagues to find solutions to the high cost of prescription drugs without reducing access to necessary treatments.

On Payment for FFR/iFR Technologies

Question. CMS has recently committed to reexamining the Medicare payment policy for specific procedures performed in an Ambulatory Surgical Center (ASC) to ensure that physicians can "exercise their clinical judgement in making site-of service determinations." One such policy that warrants reexamination is the ASC payment for fractional flow reserve and instantaneous wave-free ratio (FFR/iFR), technologies that accurately measure blood pressure and flow through a specific part of the coronary artery which can be critical for physicians in making treatment decisions for their patients.

Many doctors rely on these technologies to assess whether to perform percutaneous coronary intervention (PCI), driving improvements in quality of care and cost savings. However, the current Medicare ASC payment policy to package pay-

ment for FFR/iFR results in a payment rate that is three times lower than the outpatient hospital setting, where a complexity adjustment accounts for the cost of this important technology. The current ASC payment policy for FFR/iFR has made these procedures out-of-reach for physicians and Medicare beneficiaries in an ASC. Many stakeholders, including the Society for Cardiovascular Angiography and Interventions (SCAI) and the American College of Cardiology (ACC), have expressed concerns over this policy and have called for a change, whether by separately paying for FFR/iFR or providing a payment adjustment similar to the adjustment provided under the outpatient setting.

If confirmed as Administrator, will you commit to reexamining this ASC policy in the upcoming rulemaking cycle and considering changes to the policy to make FFR/iFR a viable option for providers and patients in an ASC?

Answer. As more and more services can be provided on an outpatient basis in various settings, we need to be thoughtful about the incentives Medicare payment policies have on utilization in these sites of care. If confirmed, I will make sure that CMS continues to examine how payment policies that vary by site of care impact quality of care and cost savings, especially for technologies that are critical for making treatment decisions.

ON VACCINES

On Seniors' Access to Preventive Care

Question. While Medicare Part B covers a number of vaccines, including for influenza, pneumococcal, and hepatitis B, with no beneficiary cost-sharing, the majority of vaccines recommended for adults, including for older adults, are covered under Part D, where seniors can face substantial copays. While cost-sharing can serve as a useful and appropriate tool in other contexts, those rationales do not apply in the case of ACIP-recommended vaccinations, and studies have shown a direct correlation between cost-sharing and increased abandonment rates for vaccines.

As a number of my colleagues and I noted in a letter we sent to CMS on this subject last summer, "A 2017 report by Avalere Health found between 47 and 72 percent of the 24 million Medicare beneficiaries with Part D coverage had some level of cost sharing for vaccines, ranging from $35 to $70 in 2015. Another study found that only 4 percent or less of Medicare Part D enrollees had access to vaccines with no cost sharing."

How can the Biden administration address the issue of ensuring medically necessary preventive care for all populations?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. I look forward to working with Congress to find ways to ensure preventive care, including recommended vaccinations, is accessible for all populations served by CMS programs. If confirmed, I will work with stakeholders and trusted partners to educate providers, beneficiaries, and families, and encourage individuals to seek preventive care.

ON MEDICARE ADVANTAGE

Question. A growing share of Medicare beneficiaries, rising from just one-quarter in 2010 to 39 percent in 2020, have chosen to enroll in Medicare Advantage (MA) plan, which enjoy a 94-percent satisfaction rate. MA has enjoyed increasingly strong bipartisan backing, with 64 senators and 339 members of the House signing on to a letter of support for the program last year.

MA plans cover an increasingly broad array of extra benefits, relative to the fee-for-service model. Of all MA plans, 88 percent cover hearing aids and 91 percent cover glasses and eye exams, while 92 percent include dental benefits and 96 percent have a fitness benefit.

Given the overwhelming bipartisan support and the additional benefits, as well as the growing competition in the MA market, what steps would you look to take, if confirmed, to continue increasing access to and education on MA options for seniors?

Answer. Medicare Advantage serves millions of Americans and is an important option for all beneficiaries, including older Americans and people with disabilities. I believe that we have to take every approach we can to provide people access to quality health care. If confirmed as CMS Administrator, I look forward to working with Congress on this important issue.

On Integrating Certain Diagnoses Obtained via Audio-Only Telehealth Visits for Risk Adjustment Purposes

Question. South Carolina has seen substantial growth in MA market penetration in recent years. As a share of all Medicare beneficiaries across the State, MA enrollment has nearly doubled in the past decade, from 16 percent of total Medicare enrollment in 2010 to 31 percent in 2020. We have also seen increased interest in Programs of All-Inclusive Care for the Elderly (PACE), another innovative model intended to drive value-based care, particularly for those dually eligible for Medicare and Medicaid. While PACE has a much smaller population of participants, more than 400 reside in SC, receiving care across three different programs, which enjoy a high satisfaction rate.

Last spring, I was pleased to see the Centers for Medicare and Medicaid Services (CMS) relax previous telehealth restrictions in Medicare to allow high-risk individuals more options for care, including allowing diagnoses obtained via telehealth to be used for risk adjustment in MA and PACE. However, CMS's guidance requires a video component to validate any diagnosis for risk adjustment purposes, even though many beneficiaries and participants have received care via audio-only visits during the pandemic, due in part to broadband and technological access gaps. According to some surveys, the majority of seniors who have access to a cell phone lack smartphone capabilities, and for many older Americans living in rural areas, including more than 27 percent of South Carolinians, broadband hurdles persist, making audio-visual visits challenging for many beneficiaries.

I have heard from plans, providers, and researchers from across South Carolina that audio-only services have accounted for a substantial portion of telehealth services during the pandemic emergency, and lower-income patients disproportionately utilize audio-only telehealth over both in-person and video telehealth services. According to CMS's data, only 65 percent of beneficiaries making less than $25,000 have access to any Internet service in their homes.

Disqualifying diagnoses obtained via audio-only telehealth services, especially for chronic conditions that have been previously documented, will result in inaccurate and incomplete documentation for MA and PACE risk adjustment purposes, arbitrarily reducing risk scores. This could lead to unequal access, fewer choices, higher premiums, or reduced benefits for seniors and individuals with disabilities.

Notably, CMS has taken the opposite approach for insurers participating in the Department of Health and Human Services (HHS)-operated risk adjustment program in the commercial market. On April 27th and August 3, 2020, the Center for Consumer Information and Insurance Oversight (CCIIO) published sets of frequently asked questions (FAQs) clarifying that HHS will allow diagnosis codes from audio-only telehealth services for risk adjustment purposes in 2020. On March 24, 2021, CCIIO issued updated FAQs stating that the policy would continue for 2021. The same logic underlying the exchange policy should justify the application of these flexibilities to MA and PACE risk adjustment as well.

If confirmed, can you commit to thoroughly reviewing this policy within the agency to ensure consistency, parity, and alignment between departments and programs regarding audio-only telehealth and risk adjustment in the future?

The deadline for plan bid submission for 2022 is less than 2 months away. Will you commit to working with my office and other interested offices on this issue to prevent adverse impacts for MA beneficiaries and PACE participants through reduced benefits, higher costs, or fewer choices next year?

I understand and share potential concerns about beneficiary, participant, and taxpayer protections around fraud, waste, and abuse. For that reason, I have partnered with Senator Cortez Masto to introduce bipartisan legislation including numerous guardrails to prevent potential misuse. Will you commit to working with us on The Ensuring Parity in Medicare Advantage for Audio-Only Telehealth Act of 2021 by providing technical assistance for congressional action or looking to it as a potential guide for implementing policy changes within the agency?

Answer. Medicare Advantage serves millions of Americans and is an important option for Medicare beneficiaries. During the pandemic, we have been able to see the value telehealth brings for patients, including those enrolled in Medicare Advantage. If confirmed, I look forward to working with you to ensure that beneficiaries enrolled in Medicare Advantage plans can continue to benefit from these services.

ON PENDING DME RULE

Question. Last year, CMS issued a Durable Medical Equipment (DME) proposed rule that would make the 50/50 blended rate for rural areas permanent. Rural access to services and care has been a longtime priority for me, given that more than one-fourth of South Carolinians live in rural areas. The proposed rule would also create a pathway for drugs requiring health-care professional administration to be covered for home infusion, helping to address an urgent challenge that the pandemic has exacerbated.

I appreciate all of the work that CMS has undertaken thus far regarding the Medicare Durable Medical Equipment benefit, and we appreciate the agency's engagement with stakeholders regarding refinements to this and other rules.

Can you commit, if confirmed, to working to finalize the DME rule as efficiently as practicable?

Answer. I recognize that rural areas have unique needs and challenges, including access to durable medical equipment. If I am fortunate enough to be confirmed, I am happy to look into the status of this regulation and work with you and your office on this important issue.

ON MEDICAID WORK REQUIREMENTS

Question. A report on health equity that you co-authored last year criticized work requirements and the Trump administration's public charge rule, writing that both policies "disproportionately impact people of color" and "perpetuate historic structural inequities and widen the health equity gap." The report described both as "discriminatory policies."

In 1996, bipartisan majorities in both chambers of Congress voted to pass the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which President Clinton signed into law, authorizing work requirements for a number of safety-net programs. As Democrats and Republicans who supported the legislation at the time explained, these requirements aimed to encourage self-sufficiency and promote opportunity. What did you mean, last year, when you described work requirements as "discriminatory," and do you stand by that assessment?

Do you believe in the core principle of welfare-to-work—namely, that workforce entry or reentry provides the ideal avenue out of poverty and dependency?

Answer. Medicaid is an important lifeline for many American families. Section 1115 demonstration projects, or waivers, are one available tool to States to help test new and innovative policies in Medicaid. I have worked closely with States throughout my career, so I know they face different challenges and need consistency and predictability. If confirmed, I will keep in mind what I have learned working on behalf of States to make sure waiver requests are appropriately evaluated while giving them consistent guidance. I will support State innovation and the ability of States to test out different models that meet the objectives of the Medicaid program. I look forward to seeing the ideas States bring to the table and will consider each one on its merits.

ON SUPPORT FOR NURSING HOME I–SNPS

Question. As you know, Institutional Special Needs Plans (I–SNPs) are a type of Medicare Advantage plan where the only beneficiaries enrolled are seniors living in nursing homes. When nursing homes offer these plans, they are 100-percent at risk for all the care their residents need, either at their facilities or elsewhere. In the push towards value-based care, nursing homes taking on risk via I–SNPs are doing exactly what we want to see, but in 2020, being 100 percent at risk for a population exclusively made up of the individuals most vulnerable to COVID–19, and most likely to need high-cost hospitalization, created serious financial challenges for nursing homes with I–SNPs, including numerous communities in South Carolina. While nursing homes in general have received funds from the Provider Relief Fund (PRF), neither HHS nor CMS has provided relief to address the specific challenges nursing home I–SNPs have faced in order to ensure this model's continued viability.

Will you commit to using administrative authority to support I–SNPs and to recognize the significant increased and unexpected costs that these plans have faced during the COVID–19 emergency?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has affected the Nation's nursing home residents. Nursing home care will absolutely be

a focus of mine if confirmed. Medicare Advantage serves millions of Americans, and Institutional Special Needs Plans provide important options for people in need of the level of care provided in nursing homes and long-term care facilities. This pandemic has given us the opportunity to take in lessons across a variety of issues. Moving forward, it is critical we examine every approach we can to improve affordability, quality, and access in long-term care. If confirmed as CMS Administrator, I look forward to working with you and other members of Congress to find ways to achieve this important goal.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. Biosimilar medicines are projected to save more than $100 billion in the next 4 years and increase patient access to lifesaving medicines. Recent analysis found roughly 40 percent of first generics are not covered under Part D 3 years after launch. Over the last 10 years, generic medicines have been increasingly placed on higher cost-sharing tiers in Medicare Part D. I have been an advocate for the creation of a specialty tier to provide lower cost-sharing for biosimilars and specialty generics.

What steps could CMS take to encourage the use of lower-cost biosimilars and generics?

Will you work with Congress to ensure generics are covered soon after launch and seniors are provided rapid access to these lower-cost medicines?

Will you work to reverse the trends of generics being placed on the inappropriate Part D tier in order to ensure patient access to low-cost generics with low cost sharing?

Answer. Prescription drug costs are too high for American patients and families. From the meetings I have had with Senators in recent weeks, I have seen that lowering drug prices is a priority on both sides of the aisle. I agree that patient access to lower-cost generics and biosimilars is important. Competition in the market has helped control the growth in spending on prescription drugs, and generics biosimilars certainly have a role to play in creating competition for reference products. If I am fortunate enough to be confirmed, I look forward to working with you and other members of Congress to lower the cost of prescription drugs.

Question. I recently sent a letter to GAO alongside many of my colleagues asking for an investigation into some recent reports on fraud in the Medicaid program.

What holes in the system did you see when you worked as a program analyst for Medicaid, and what possible solutions do you look toward to help solve the problem?

Answer. Fighting fraud and abuse is so important for maintaining a strong Medicaid program. Medicaid is a critical lifeline for beneficiaries across the country. If I am fortunate enough to be confirmed, I will be prepared to work with you, other members of Congress, and States to make sure that payments are made properly and we are good stewards of the Medicaid program and taxpayer dollars.

Question. The pandemic has underscored the importance of managing and preventing chronic disease and removing health disparities. We also recognize that higher out-of-pocket costs correlate with less prescription drug access. To this end, we need to be proactive and address system challenges that inadvertently drive out-of-pocket costs up for seniors. For example, certain system fees, called DIR fees, lead to increased costs for seniors at the pharmacy counter, while also threatening the viability of pharmacies across the Nation, leading to gaps in care. As you are aware, the Centers for Medicare and Medicaid Services (CMS) has estimated that pharmacy DIR fee reform could result in saving Medicare beneficiaries between $7.1 and $9.2 billion in cost sharing burden over the next decade.

To reduce out-of-pocket costs for seniors and safeguard access to care provided at local pharmacies, how will you commit to DIR fee claw-back reform and the establishment of standardized performance measures for pharmacies in Part D to help drive quality for seniors and control rising costs?

Answer. Small and rural pharmacies are critical to our Nation's health-care system and have been especially important during the pandemic. It can be hard for these pharmacies to predict retroactive DIR fees. We must do all we can to ensure that Americans can access important health-care services, including from local pharmacies in their communities. If confirmed, I look forward to working with Congress to ensure that pharmacies have predictability.

Question. As you know, the Medicare Advantage institutional special needs program is an important source of personalized support for long-term care residents. It has proven to deliver quality care with supplemental benefits at a lower cost. As a result, Congress has seen the value and made the I–SNP program permanent. Since I–SNPs only serve long-term care populations, they cannot shift the risks they may assume. One of these plans is currently servicing several of the long-term care facilities in Oklahoma and, unsurprisingly, the COVID pandemic has had a particularly devastating effect on them, as nursing home residents continue to be on the front lines of those most negatively impacted. Special needs plans have fallen through the cracks of COVID support and have been subject to unintended consequences, leading to enrollment disincentives and further increasing the pressure on I–SNPs.

Do you acknowledge that the I–SNPs are facing a significant problem?

If so, will you commit to working with the struggling plans to address the disparities they currently face, ensuring there are equitable private options available for nursing home residents, and finding a solution?

If not, please explain why.

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has affected the Nation's nursing home residents. Nursing home care will absolutely be a focus of mine, if confirmed. Medicare Advantage serves millions of Americans, and Institutional Special Needs Plans provide important options for people in need of the level of care provided in nursing homes and long-term care facilities. I agree that it is critical we examine every approach we can to improve affordability, quality, and access in long-term care. If confirmed as CMS Administrator,

I look forward to working with you and other members of Congress to find ways to achieve this important goal.

Question. Your career has focused on expanding health coverage for Americans.

If confirmed, do you plan to increase the role of the Federal Government in health care by promoting a public option? Please detail your plans for expanded health coverage.

Answer. President Biden has been clear that his goals for improving the American health-care system begin with building on the successes of the Affordable Care Act, and I am committed to working toward that goal. Ensuring that all Americans have access to affordable, quality health care will be a priority of mine. I want to work with States to expand coverage through Medicaid and the Marketplaces. I look forward to working with you to expand access to affordable, quality health care.

QUESTIONS SUBMITTED BY HON. STEVE DAINES

Question. One of the silver linings of this pandemic has been the wide-spread adoption of technology to bring people together, whether it be families scattered across the Nation or patients and their providers. Telehealth has truly taken root, and we have seen exponential growth in telehealth adoption across Americans of all ages, locations and conditions. Much of the growth in usage among Medicare beneficiaries has been made possible by temporary flexibilities in place for the duration of the public health emergency. These include allowing Medicare beneficiaries to have telehealth visits from their home, regardless of where they live across the country. This has also allowed new types of providers, such as physical therapists and speech pathologists to practice via telehealth.

Do you agree that the expanded access to telehealth services has been an important component in protecting patients and providers during the Nation's response to COVID–19?

As Congress considers permanent telehealth reform, I hope you will be willing to work with us to ensure that telehealth is available to all of those that wish to use it. Do you believe that there are some telehealth regulatory restrictions that Congress and CMS can work together to address in the near term?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe. My brother is a psychologist, and telehealth has really helped his patients get the care they need. If I am fortunate enough to be confirmed, I will be taking a careful look at the telehealth flexibilities under Medicaid and Medicare before the Public Health Emergency ends.

I want to look at what we can and should extend administratively and what will need congressional action to ensure that we bring the lessons learned about telehealth during the pandemic into our health-care system going forward. I look forward to hearing more from you about what existing flexibilities you view as especially important.

Question. Emerging science indicates that addressing risk factors—including cardiovascular disease, diabetes, obesity, and hypertension—can delay the onset of dementia and Alzheimer's. However, we continue to see our health-care system, particularly Medicare, fail to pursue low-cost, effective policies to reduce the risk for chronic conditions, including Alzheimer's. Instead, our system waits until people are sick and treatment costs are significantly higher.

If confirmed, how will CMS pursue wellness and early intervention policies that reduce the risk of chronic diseases like Alzheimer's?

Answer. Alzheimer's disease is a devastating condition for patients and families. It is only going to be a growing challenge for the Medicare program and our aging population in coming years. Preventive care is crucial to improving health outcomes, and it is so important to catch the signs of cognitive impairment early. I'd be happy to work with you on this should I be confirmed.

Question. Late last year, CMS issued a Durable Medical Equipment proposed rule, which would make the 50/50 blended rate for rural areas permanent. This rule has not been made final as of yet. I appreciate all the work HHS and CMS have done regarding the Medicare Durable Medical Equipment benefit.

When will HHS and CMS issue the final DME rule?

Answer. I recognize that rural areas have unique needs and challenges, including access to durable medical equipment. If I am fortunate enough to be confirmed, I am happy to look into the status of this regulation and work with you and your office on this important issue.

Question. The coronavirus pandemic has underscored the value of vaccines for infectious diseases, including those that originate abroad. We all recognize that COVID–19 will not be the last time we have to respond to an outbreak for which vaccinations are necessary in order to stem an emerging public health threat.

Public policy should make vaccines as accessible as possible for our citizens. That is why current law requires that insurers provide coverage without cost sharing for all recommended vaccines, without limitation.

Yet, inexplicably, current HHS regulations implementing the law limit mandatory coverage to so-called "routine" vaccines on the Immunization Schedules. As a result, many vaccines for infectious diseases are not covered without cost-sharing, including those for current vaccines such as rabies, anthrax, Japanese Encephalitis, yellow fever and cholera, and those vaccines in the pipeline for malaria, chikungunya, dengue, and Zika.

Last year, my colleagues and I worked on bipartisan legislation included in the CARES Act that ensures immediate coverage of COVID–19 vaccines with no cost-sharing. As I said then, Montanans and Americans across the country need access to vaccines, and financial barriers should not stand in the way during a national emergency or otherwise.

Congress should not have had to be reactive. A forward-looking, uniform approach is needed to ensure that we are prepared to move quickly on vaccinations when the next pandemic occurs.

If confirmed, will you commit to quickly bringing agency regulations in line with the statute requiring no cost-sharing for all CDC recommended vaccines to maximize access to the best preventative measures against infectious diseases?

Answer. I agree that the COVID–19 pandemic has underscored the importance of vaccines to preventing the spread of disease, and I agree that we should remove barriers for patients to get proven vaccines. We need to be prepared for any potential future outbreak, and I agree we cannot afford to be reactive on such an important issue. I am happy to work with you to ensure we are ready for the next public health emergency.

QUESTIONS SUBMITTED BY HON. TODD YOUNG

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

Question. The Center for Medicare and Medicaid Innovation (CMMI) is charged with testing and evaluating voluntary healthcare payment and service delivery models with the intent of increasing quality and efficiency while reducing program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

As we discussed during our meeting, I feel there is absolute value in innovating with health-care payment and service delivery systems. We won't know if we're truly making a difference unless we test and evaluate—it's how we find out what works and what's most effective for patients and doctors alike.

However, the actual experience of CMMI can too often be marked by a lack of transparency and little stakeholder engagement in the development and implementation of models.

At times, models also seem to initiate wholesale policy changes rather than serve as true tests, circumventing Congress's role in establishing Medicare policy. I also want to ensure that proposed models sufficiently take into consideration the potential health-care access disparities for vulnerable populations.

Will you work with the members of this committee on establishing protections to guarantee better transparency, stakeholder input, data sharing, and equity in the development of proposed models by CMMI?

Will you commit to come back to this committee to share updates and release progress reports on CMMI actions and models?

Answer. The Innovation Center has been an important tool to test new models to move our health-care system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't and chart a path forward from there. This includes getting stakeholder input, and if I am fortunate enough to be confirmed, it will be a priority for me to have open lines of communication with Congress. I look forward to hearing from you about CMMI models.

TELEHEALTH

Question. Even prior to the pandemic, I heard from my constituents in Indiana—particularly those in rural areas—about the ways in which telehealth can both increase access to underserved Americans and reduce health-care costs. Since the start of the public health emergency, telehealth flexibilities provided by Congress and HHS have been a lifeline for vulnerable seniors and others accessing care from the safety of their own homes.

Currently, authorizations included in the CARES Act to create additional flexibility for patients and providers using telehealth only extend through the pandemic.

We don't want to take a step back on telehealth. The Medicare Payment Advisory Commission (MedPAC) has recommended that we should "temporarily continue some of the telehealth expansions for a limited duration of time (*e.g.,* 1 or 2 years after the public health emergency) to gather more evidence about the impact of telehealth on beneficiary access to care, quality of care, and program spending to inform any permanent changes." What data or evidence is CMS collecting now to determine what waivers should be made permanent?

How should telehealth be used moving forward to expand access to mental and behavior health services for Medicare beneficiaries?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe. My brother is a psychologist, and telehealth has really helped his patients get the care they need. If I am fortunate enough to be confirmed, I will be taking a careful look at the telehealth flexibilities under Medicaid and Medicare before the Public Health Emergency ends to determine what we can extend administratively and what we will need Congress's help on to ensure that we use the lessons learned about telehealth during the pandemic to modernize our health-care system.

ORGAN PROCUREMENT

Question. Thirty-three Americans die every day waiting for a lifesaving organ transplant, and Medicare spends roughly $36 billion annually on care for dialysis patients because there are not enough kidney transplants available to meet the need. The problem is a network of unaccountable government monopoly contractors that run the organ donation system, called organ procurement organizations (OPOs), with a history of severe performance failure.

Recently, CMS finalized a rule started in the previous administration that would allow HHS to replace failing OPOs with high performers, and is projected to save more than 7,000 additional lives every year, as well as over $1 billion annually to Medicare.

This rule has broad bipartisan support, and is even more important since COVID–19 damages organs. As CMS Administrator, will you commit to its swift implementation?

Answer. Thank you for bringing up this important issue. Federal law tasks CMS with conducting surveys of OPOs and recertifying them. As you noted, the rule replacing current OPO measures with new transparent, reliable, and objective outcome measures is now effective. My understanding is that the new outcome measures will be implemented on August 1, 2022, the start of the next recertification cycle. If confirmed, I will work to implement this rule in a timely way and ensure that all parts of the organ transplant system are as effective and efficient as possible in order to save as many lives as possible.

MEDICARE ADVANTAGE

Question. We have seen a growth in the private/public partnership program in Medicare Advantage (MA). Over 40 percent of Medicare beneficiaries are choosing Medicare Advantage and they report high satisfaction with the provider networks, cost savings and coordinated care.

What role do you see Medicare Advantage having in the future of Medicare as we work towards modernizing the program?

Medicare Advantage is showing that it can provide lower consumer costs, offer additional benefits, and achieve better outcomes, like fewer avoidable hospitalizations including for high need, high risk patients for the same or lower cost as FFS Medicare.

Research from UnitedHealth Group shows that Hoosiers enrolled in a Medicare Advantage plan spend nearly $1,800 *less* on premiums and out-of-pocket costs than a Hoosier enrolled in traditional Medicare and a prescription drug plan; and, in addition to the dental, vision, and hearing benefits typically offered, the average MA beneficiary in Indiana receives $170 annually in additional benefits such as care coordination, meals, and non-emergency transportation not offered by traditional Medicare.

Do you see Medicare Advantage as an important part of modernizing Medicare while getting better results for our taxpayer dollars?

What will you do to protect this public/private partnership and keep the program strong?

Answer. Medicare Advantage serves millions of Americans and is an important option for Medicare beneficiaries. I believe that we have to take every approach we can to provide people access to quality health care. If confirmed as CMS Administrator, I look forward to working with Congress on this important issue.

SEPSIS TESTING STANDARD OF CARE

Question. More than 20 million Americans present with symptoms of sepsis in acute care hospitals annually, and are treated under a "sepsis protocol" where blood culture tests are urgently drawn to diagnose bloodstream infections. However, approximately 40 percent of these blood culture tests are false positives. This results in patients being subjected to extended hospital stays and the unnecessary use of potent antibiotics, which have been proven to contribute to the spread of antibiotic resistance.

What is CMS doing to ensure that hospitals across the country are working to reduce their false positive sepsis test rates to ensure patient safety?

Answer. Thank you for raising this important issue. Timely diagnosis and treatment of sepsis is a critical issue as are actions that will enhance antibiotic stewardship. If confirmed, I look forward to working with you to continuously improve the quality of care that hospitals are providing to patients, including with respect to accurately diagnosing sepsis while avoiding unnecessary use of antibiotics.

END STAGE RENAL DISEASE (ESRD)

Question. Last November, my staff shared some concerns we heard from representatives of the kidney care community about the proposed methodology to incorporate certain drugs into the ESRD bundle. There have been reports of dialysis patients on these therapies being forced off treatments that are working for them onto therapies that have not worked for the patient in the past.

As CMS Administrator, how you will ensure patient quality of care is not being impacted—specifically for communities of color who are disproportionately impacted by kidney disease—so that patients can continue to access these medicines best suited for their treatment?

Answer. I agree that is it important for Medicare beneficiaries, particularly patients with complex conditions such as ESRD, to have access to medically necessary treatments. Promoting health equity—particularly for communities of color and rural areas—needs to be at the forefront of CMS decision making. If confirmed, I will work to preserve access to these treatments in Medicare and improve patient outcomes.

QUESTIONS SUBMITTED BY HON. BEN SASSE

TELEHEALTH

Question. While my colleagues have pointed out many of the ways COVID–19 has challenged our health-care system and exposed existing inequities, one bright spot in the pandemic has been increased access to telehealth services as a way for patients to maintain their health from the safety of their homes. This has been particularly important for States like Nebraska with large areas of rural population.

We know that CMS has allowed expanded use of audio-only services during the pandemic, but how is CMS working to ensure that those without broadband access can utilize appropriate telehealth services in a post-pandemic world?

Where do you stand on audio-only telehealth coverage? What about on payment parity between in-person and virtual services?

How will you approach geographic restrictions, both in patient location and provider licensure?

If confirmed, how do you plan to evaluate the use of telehealth over the last year and the places where it should—and potentially should not—be expanded beyond the end of the national emergency period?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers, and their families safe. My brother is a psychologist, and telehealth has really helped his patients get the care they need. If I am fortunate enough to be confirmed, I will take a careful look at the telehealth flexibilities under Medicaid and Medicare before the Public Health Emergency ends. During that review, I will pay special attention to the issues of equity and access. I will look at what we can and should extend administratively and where we will need Congress's help to ensure that we bring the lessons learned about telehealth during the pandemic forward to modernize our health-care system.

Question. Individuals with chronic disease place an immense strain on our health-care system and account for a huge percentage of the overall costs to taxpayers. I think you would agree that early identification and treatment is crucial not only among those with chronic diseases but in our health systems in general. Remote patient monitoring (RPM) can be beneficial in managing both acute and chronic conditions and identifying deteriorations in health as early as possible to allow for the best level of care. Issues with reimbursement continue to constrain Medicare recipients' access to this level of monitoring.

Do you see value in increased access to remote patient monitoring and what are your views on the co-pay requirement for these services?

Answer. Individuals with chronic disease benefit from access to comprehensive and coordinated care to manage and treat their chronic conditions and prevent the need for more costly care. Ensuring access to remote patient monitoring services, including through evaluating the adequacy of payments, will be important to beneficiaries who may benefit from these and other virtual services that allow their physicians to help manage and treat their health conditions outside of regular office visits.

MOST FAVORED NATION MODEL

Question. I have concerns with the Most Favored Nation model rulemaking, both with the policy of tying Medicare reimbursements to the prices foreign countries pay and with the creation of the expansive rule through the Center for Medicare and Medicaid Innovation (CMMI) under the guise of being a pilot program.

If confirmed, how will you approach this policy? Do you support tying the prices of American drugs to foreign prices?

Will you commit to ensuring that CMMI is used as intended rather than as a congressional workaround?

Answer. Prescription drug costs are too high for American patients and families. From the meetings I have had with Senators in recent weeks, I have seen that this is a priority on both sides of the aisle. I think there is an opportunity for real impact here to lower prescription drug costs, and—if I am fortunate enough to be confirmed—I look forward to working with you and other members of Congress to achieve that goal.

Regarding the Center for Medicare and Medicaid Innovation, the Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. With 10 years of experience to learn from at the Innovation Center, we need to look at what has worked and what hasn't, and I look forward to hearing from you about what you think is working well and what experiences you've seen on the ground in Nebraska.

MEDICAID

Question. Enrollment in the Medicaid program has exploded during the pandemic, partially due to problematic language in last year's relief bills where States have no choice but to provide services even to people who are not actually eligible for the program. The Families First Coronavirus Response Act (FFCRA) offered States an increased Federal Medical Assistance Percentage (FMAP) for their traditional Medicaid populations and in turn restricted them from maintaining control over their Medicaid programs via maintenance-of-effort requirements. Across the country there are millions of Medicaid enrollees whose redetermination has been delayed, and in just seven States where we have data we know that roughly half a million enrollees are receiving benefits who are ineligible for the program.

Do you commit to working with States and Congress to actually identify which enrollees are eligible and which are not?

Do you commit to making sure that the Medicaid program is able to serve those individuals who are truly in need?

Do you believe States should have the right to remove ineligible enrollees, which is currently restricted by FFCRA?

Answer. Medicaid is a critical lifeline for beneficiaries across the country. If I am fortunate enough to be confirmed, I will also be prepared to work with you, other members of Congress, and States to make sure that payments are made properly and we are good stewards of the Medicaid program and taxpayer dollars. The requirement related to enrollment at section 6008(b)(3) of the Families First Coronavirus Response Act for States receiving the Medicaid FMAP increase will be in effect until the end of the month in which the COVID–19 public health emergency ends. As that time grows nearer, it will be important for CMS to work closely with States to plan for the transition.

DURABLE MEDICAL EQUIPMENT

Question. HHS and CMS have done a lot of work on the Medicare Durable Medical Equipment benefit, including issuing a proposed rule late last year that would have made the 50/50 blended rate for rural areas permanent.

When does CMS plan to issue the final DME rule given the change of administrations?

Answer. I recognize that rural areas have unique needs and challenges, including access to durable medical equipment. If I am fortunate enough to be confirmed, I am happy to look into the status of this regulation and work with you and your office on this important issue.

Question. We know that some of our most vulnerable in society rely on ventilators for their care, yet access to new-generation, multi-function ventilators can often be restricted by complicated payment policies that have not adapted for new technologies. This is particularly important in light of the pandemic, when ventilation in home care settings allows for more hospital space.

If confirmed, will you work to update CMS payment regulations to account for advancements in ventilator technology, including adjusting irregularities in payment that impede patient access?

Answer. We know that some of our most vulnerable patients rely on ventilators for their care, yet access to new-generation, multi-function ventilators can often be impeded by statutory payment policies related to paying for equipment on a cap rental basis and the reasonable useful lifetime of the equipment. To help ensure access to ventilators in light of the COVID–19 public health emergency, I understand that CMS is allowing payment for multi-function ventilators even if separate devices have not met their reasonable useful lifetime.

I agree that it is incredible what science has been able to do in recent years with innovative new drugs, treatments and devices. If I am fortunate enough to be confirmed, I will make sure we are looking at modernizing the Medicare program to make sure beneficiaries have access to proven new technology, and I would be happy to work with you on that.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. At the end of 2020, Congress provided relief from reductions in reimbursement to certain physicians which was included in last year's physician fee schedule final rule. This was the result of budget neutrality requirements within the fee schedule. With many physician practices experiencing substantial challenges as a result of the COVID–19 pandemic, it is important to ensure providers are able to continue caring for patients.

Can you please discuss your approach regarding future changes to the physician fee schedule? In particular your feelings on reducing reimbursements to providers during the pandemic.

Answer. I believe that ensuring adequate payments for primary care and specialty physicians is essential to maintain beneficiary access to high-quality and affordable health care. If confirmed, I will work to ensure that payments under the Medicare physician fee schedule are implemented in accordance with the law while preserving beneficiary access.

Question. Current law requires zero cost sharing for COVID therapeutics. However, when the Public Health Emergency (PHE) is lifted many of these policies linked to the PHE declaration will no longer be in effect under the law and will potentially be subject to CMS' discretion.

Please discuss your approach to reimbursement for COVID therapeutics. In particular your feelings on how this issue should be approach once the PHE is lifted.

Answer. I appreciate Congress's leadership in making sure that patients suffering from COVID–19 have been able to get the care they need during the public health emergency. I think we need to look at the policies in place during the pandemic and determine what we should do after the pandemic is over, either administratively or with legislation from Congress. If confirmed, I will be happy to work with you and other members of Congress as we look beyond the pandemic.

Question. Drugs approved via accelerated approval at the Food and Drug Administration (FDA) are novel treatments that address urgent and unmet medical needs involving serious and life-threatening diseases.

As a doctor, I am particularly passionate about the new treatments approved through this pipeline to treat Duchenne Muscular Dystrophy. As you know, this is a deadly disease, which until very recently had no approved treatments. Today we

have five treatments approved through this pathway with many more in development. While certainly not a cure, these therapies are an important step forward.

Recently, the Medicaid and CHIP Payment and Access Commission (MACPAC) issued recommendations to increase the required Medicaid rebates for drugs specifically approved through the accelerated pathway.

While I appreciate that MACPAC is a congressional advisory body, I believe their recommendation to single out these therapies is troubling. In particular, when you consider medications approved in this manner treat some of our most vulnerable patients and make up a very small percentage of total Medicaid spending.

Can you discuss your views on Federal reimbursement policies on the development of new therapies for people with rare diseases?

Answer. Thank you for raising this important issue. It is incredible what scientific progress has been made with innovative drugs and treatments, and we need to continue to modernize the Medicare and Medicaid programs to make sure beneficiaries, including those with rare diseases, have access to proven new treatments. If confirmed, I would be happy to examine this particular MACPAC proposal in more detail, and to work with you and other members of Congress on ways to spur innovation and facilitate beneficiary access to new advances in medicine.

Question. Last year I led a bipartisan letter with Senate and House colleagues to CMS expressing concerns about cuts to hip and knee replacement in the Calendar Year 2021 (CY21) Physician Fee Schedule and the implications for value based care.

Specifically, the letter urged CMS to recognize the patient preoptimization work physicians are doing in alternative payment models. The CY'21 rule substantially cut lower joint arthroplasty even though physicians performing those procedure are doing more work and saving the Medicare Trust Funds money through their record-high participation in alternative payment models (APMs).

These cuts are concerning. This appears to be a disconnect between the legacy fee-for-service evaluation of procedures, and innovative care we are encouraging in APMs. However, the Final Rule indicated CMS's interest in capturing this patient preoptimization work.

Would you please work with the stakeholders and I on the preoptimization issue?

More broadly, can you discuss your feeling on alternative payment models and if there are specific areas where you wish to focus?

Answer. I agree that we should continue efforts to further move our health-care system towards one that rewards value over volume. Delivery system reform efforts, including alternative payment models, can improve quality of care while reducing health-care costs. The Innovation Center has been an important tool to test new models to move our system from one that rewards volume to one that rewards value. It will continue to be important, as we move forward, to test models that improve patient care, advance health equity, and lower patient costs. We have now had 10 years of experience to learn from at the Innovation Center. We need to look at what has worked and what hasn't, and if confirmed, I will work with you to make sure we recognize the good work providers are doing to move our system in the right direction, improve care, and lower Medicare spending.

Question. I support price transparency in the health-care system. The Trump administration made good progress on this problem with their hospital price transparency rule, which went into effect on January 1, 2021.

It appears from media reports that many hospitals are not following the rule. If confirmed, how will you address price transparency in health care, especially in terms of enforcement of the price transparency rule?

Answer. I agree that the variation in pricing across hospitals is not always justified and ultimately can be bad for consumers. For transparency measures to work properly, patients and their families must be able to understand them in a meaningful way. If I am fortunate enough to be confirmed, I look forward to continuing to work on this issue.

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

When we held our hearing for Xavier Becerra to be the Secretary of Health and Human Services, I noted the size and importance of the Department he would lead. In normal times, HHS and its agencies provide health-care coverage to nearly 150 million people, and those agencies affect the lives of many more on a daily basis. The COVID–19 pandemic has raised the salience of the Department.

The Department's leadership, including the Deputy Secretary, will continue to play a key role in bringing us out of the public health emergency. Similarly, Medicare and Medicaid are providing essential health care to patients who have suffered disproportionately from the COVID–19 pandemic.

Looking to the future, the Secretary, the Deputy Secretary, and the CMS Administrator must carefully evaluate how best to use the resources available to them to promote the health care of our citizens. They must do so carefully, constructively, and creatively.

Two months ago, I outlined several issues in the health-care space where I intend to focus my efforts as ranking member, including fostering innovation to improve patient care and make our health-care system more efficient. The COVID–19 pandemic has threatened Americans' physical and economic health, but it has also reinforced the value of innovation and provided an opportunity to test changes that foster it.

HHS has used its authority under the public health emergency to waive numerous requirements to ensure Medicare and Medicaid beneficiaries and other patients receive care during the pandemic. Patients and providers have benefited from expanded access to telehealth and expedited approval of COVID–19 vaccines, diagnostics, and treatments. Going forward, Medicare and Medicaid patients must have the same access to innovative items and services as those with commercial insurance.

We must carefully evaluate our response to the pandemic and implement appropriate reforms based on the lessons we have learned. HHS should partner with this committee in that effort. However, media reports about certain health-care policies that may come before Congress or be enacted through executive actions are concerning. Some of these policies, such as including additional benefits under Medicare, could experience bipartisan support if considered through a transparent, cooperative process.

Unfortunately, reconciliation does not afford Congress the opportunity to work together to evaluate these changes and make necessary reforms to protect the long-term financial viability of the program. Other policies, such as expanding Obamacare's premium subsidy to everyone, regardless of income, would be incredibly expensive for taxpayers without taking appropriate steps to lower the cost of health insurance. Creative, bipartisan ideas to lower the cost of insurance in the individual market have been raised by States and my colleagues on this committee.

I welcome the opportunity to work together on some of these ideas, such as allowing States to use waivers to their full potential, diversifying benefit designs, and incentivizing competition.

Finally, I am concerned about paying for some of these policies through changes to our drug pricing system that could stifle innovation. We can see the end of the COVID–19 pandemic approaching, thanks to groundbreaking vaccines developed by pharmaceutical manufacturers. In this crisis, industry responded to the Nation's call to arms, code-named Project Warp Speed, developing powerful and effective vaccines in record time. This success was possible because of the private sector.

I strongly agree with my colleagues that this innovation is only valuable if patients can afford it. We should establish an out-of-pocket spending cap and reform Medicare Part D with the market-based principles of competition and transparency in mind.

Ms. Palm and Ms. Brooks-LaSure, if you are confirmed, I look forward to working with you to improve our health-care system. I ask you to commit to careful assessments of the risks and considerations in every policy decision you make. Political pressures may make unilateral action seem attractive, but you should also consider how the market, individual choice, public policy, and incentives play vital roles in the development and delivery of health care.

I look forward to hearing your testimony and your responses to questions. The positions to which you have been nominated have substantial influence over policy. The members of this committee need to understand how you will implement the administration's agenda.

We expect your answers, here and in response to QFRs, to be detailed and candid.

PREPARED STATEMENT OF ANDREA JOAN PALM, NOMINATED TO BE DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you, Chairman Wyden, Ranking Member Crapo. I am grateful for the opportunity to testify before you today as President Biden's nominee for Deputy Secretary of the United States Department of Health and Human Services. I want to thank Senator Tammy Baldwin for the kind introduction and for her work on behalf of the people of Wisconsin. And thank you to the members of this committee for considering my nomination. I've enjoyed the opportunity to speak with many of you individually.

I was born and raised in Star Lake, NY—a town of about 1,000 people. When you grow up in a small town, you understand from a young age that together is the only way to get things done. That sense of community was formative and is what led me to become a social worker. I spent my twenties as a caseworker, finding safe homes for children in crisis and working for people with behavioral health needs.

These experiences shaped the rest of my career. It was the children and families I worked with during this time that made me want to change the system and drew me to public policy and public service. The memories of these kids still motivate me today.

I've spent my entire career focused on health and human services policy and lifting up our most vulnerable communities, from my time in the Senate working on the HITECH Act to serving at HHS, where I played a key role implementing the Affordable Care Act and negotiating bipartisan policies like the 21st Century Cures Act.

Most recently, I had the privilege of leading Wisconsin's Department of Health Services. I'm proud of the work I was able to accomplish in Wisconsin. There, we found ways to make progress on a bipartisan basis, expanding access to telehealth services and our innovative Children's Health Insurance Program, and improving delivery of the Departments' programs to better serve the people of Wisconsin.

And when the pandemic hit, we led with facts, science, and transparency to protect our communities. As every single State did, we faced obstacles. But we built a strong State-wide response—leveraging government assets and the expertise of the private sector—to build stable testing and contact tracing programs, reach rural communities, and vaccinate Wisconsinites.

And it's working. Wisconsin is among the top States in vaccinating its residents.

When I was previously at HHS, then-Secretary Burwell would joke that if there was an issue that was going to require bipartisan cooperation, the team should give it to me. She called my portfolio the "common ground agenda." And if I have the honor of being confirmed and returning to HHS, that's what I'm bringing with me: a common-ground agenda.

First, we must end the COVID–19 pandemic. I know we can all agree we have lost far too many Americans to this virus. President Biden put forward ambitious goals, and Congress has followed through, providing the resources to get the job done. If confirmed, I look forward to implementing the American Rescue Plan, getting vaccines in arms, rebuilding a public health workforce, and securing this Nation's supply chain.

Second, we must expand access to high-quality, affordable health care. The American Rescue Plan took major steps to bring down the cost of health care for working families, but we can't stop there. We must strengthen our Medicare and Medicaid lifelines; reduce the cost of prescription drugs; better integrate mental health and substance use disorder treatment into our health-care system; maintain our global leadership in research, development and innovation; and ensure that all Americans have access to quality, affordable health care.

Finally, we must prioritize human services. HHS has an important role to play. From caring for children, to advancing the health and well-being of people with disabilities, we must not lose sight of these core missions.

HHS faces big challenges. And it's our responsibility to be tireless stewards of an agency that touches nearly every aspect of American life. To me, that's what public service is all about: making government work for the people, and leaving the country better than we found it.

I am ready for the task, and eager to continue serving. Thank you for considering my nomination.

SENATE FINANCE COMMITTEE

STATEMENT OF INFORMATION REQUESTED OF NOMINEE

A. BIOGRAPHICAL INFORMATION

1. Name (include any former names used): Andrea Joan Palm.
2. Position to which nominated: Deputy Secretary, U.S. Department of Health and Human Services.
3. Date of nomination: January 18, 2021.
4. Address (list current residence, office, and mailing addresses):
5. Date and place of birth: October 5, 1972, Star Lake, NY.
6. Marital status (include maiden name of wife or husband's name):
7. Names and ages of children:
8. Education (list all secondary and higher education institutions, dates attended, degree received, and date degree granted):

   Washington University.
   Dates Attended: August 1994–May 1996.
   Degree Received: Master of Social Work.
   Date Degree Granted: May 1996.

   Cornell University.
   Dates Attended: August 1990–May 1994.
   Degree Received: Bachelor of Science.
   Date Degree Granted: May 1994.

   Clifton-Fine Central.
   Dates Attended: 7th–12th grade, September 1985–June 1990.
   Degree Received: High School Diploma.
   Date Degree Granted: June 1990.

9. Employment record (list all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment for each job):

   Wisconsin Department of Health Services.
   Secretary-designee.
   January 2019–January 2021.
   Madison, WI.

   U.S. Department of Health and Human Services.
   Senior Counselor to the Secretary (January 2015–January 2017).
   Chief of Staff (April 2013–December 2014).
   Counselor to the Secretary for Public Health (October 2011–April 2013).
   Senior Advisor to the White House Domestic Policy Council (detailed from HHS; August 2010–October 2011).
   Acting Assistant Secretary for Legislation (August 2009–July 2010).
   Deputy Assistant Secretary for Public Health Legislation (January 2009–July 2009).

Washington, DC.

Office of Senator Hillary Clinton.
Senior Health Policy Advisor (January 2008–Janaury 2009).
Legislative Assistant (June 2004–January 2008).
Washington, DC.

Office of Congressman Robert T. Matsui.
Legislative Director (December 2003–May 2004).
Senior Legislative Assistant (June 2001–December 2003).
Washington, DC.

Volunteers of America.
Government Relations Manager (June 2000–May 2001).
Public Policy Associate (October 1998–June 2000).
Alexandria, VA.

City of Phoenix.
Policy Analyst, Human Services Department.
June 1997–September 1998.
Phoenix, AZ.

Arizona Justice Institute.
Equal Justice Fellow (Policy Analyst).
October 1996–May 1997.
Phoenix, AZ.

ComCare.
Crisis Counselor.
January 1996–September 1996.
Phoenix, AZ.

Life Crisis Services.
Development Director (part-time).
August 1995–December 1995.
St. Louis, MO.

St. Louis Circuit Attorney's Office.
Victim Services Caseworker (part-time).
January 1995–December 1995.
St. Louis, MO.

Children's Home and Aid Society.
Crisis Counselor.
September 1994–December 1994.
Mobile position; territory included the northern St. Louis, MO suburbs.

10. Government experience (list any current and former advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments held since college, including dates, other than those listed above):

None.

11. Business relationships (list all current and former positions held as an officer, director, trustee, partner (*e.g.,* limited partner, non-voting, etc.), proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, other business enterprise, or educational or other institution):

None.

12. Memberships (list all current and former memberships, as well as any current and former offices held in professional, fraternal, scholarly, civic, business, charitable, and other organizations dating back to college, including dates for these memberships and offices):

Arizona Arts Chorale.
President (1997–1998).
Member (1996–1998).

Chi Omega Sorority.
Alumna (1994–present).
President (1993–1994).
Rush Chair (1992–1993).
House Manager (1991–1992).

13. Political affiliations and activities:

a. List all public offices for which you have been a candidate dating back to the age of 18.

None.

b. List all memberships and offices held in and services rendered to all political parties or election committees, currently and during the last 10 years prior to the date of your nomination.

None.

c. Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of $50 or more for the past 10 years prior to the date of your nomination.

See Table.

Contribution Description	Date	Amount
HILLARY FOR AMERICA	2016–07–24	$1,500.00
HILLARY FOR AMERICA	2016–08–31	$50.00
HILLARY FOR AMERICA	2016–09–21	$50.00
HILLARY FOR AMERICA	2016–09–26	$50.00
HILLARY FOR AMERICA	2016–10–19	$100.00
HILLARY FOR AMERICA	2016–10–27	$50.00
HILLARY FOR AMERICA	2016–10–29	$50.00
HILLARY FOR AMERICA	2016–10–31	$50.00
HILLARY FOR AMERICA	2016–11–01	$50.00
HILLARY FOR AMERICA	2016–11–03	$50.00
LAUREN UNDERWOOD FOR CONGRESS	2018–05–07	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–22	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–22	$100.00
HALEY STEVENS FOR CONGRESS	2018–09–22	$250.00
SINEMA FOR ARIZONA	2018–09–22	$100.00
BREDESEN FOR SENATE	2018–09–22	$100.00
BETO FOR TEXAS	2018–09–22	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–29	$50.00
LAUREN UNDERWOOD FOR CONGRESS	2018–09–29	$50.00
ROSEN FOR NEVADA	2018–09–30	$100.00
SINEMA FOR ARIZONA	2018–09–30	$100.00
HALEY STEVENS FOR CONGRESS	2018–09–30	$100.00
HALEY STEVENS FOR CONGRESS	2018–09–30	$100.00
HEIDI FOR SENATE	2018–09–30	$250.00
BREDESEN FOR SENATE	2018–09–30	$100.00
DONNELLY FOR INDIANA	2018–09–30	$250.00

Contribution Description	Date	Amount
HEIDI FOR SENATE	2018–10–04	$250.00
ROSEN FOR NEVADA	2018–10–05	$100.00
ROSEN FOR NEVADA	2018–10–05	$100.00
ROSEN FOR NEVADA	2018–10–08	$100.00
ROSEN FOR NEVADA	2018–10–08	$100.00
HEIDI FOR SENATE	2018–10–08	$100.00
HEIDI FOR SENATE	2018–10–08	$100.00
ROSEN FOR NEVADA	2018–10–17	$100.00
ROSEN FOR NEVADA	2018–10–17	$100.00
DONNELLY FOR INDIANA	2018–10–18	$150.00
DONNELLY FOR INDIANA	2018–10–18	$150.00
BREDESEN FOR SENATE	2018–10–18	$100.00
BREDESEN VICTORY FUND	2018–10–18	$100.00
HALEY STEVENS FOR CONGRESS	2018–10–27	$50.00
HALEY STEVENS FOR CONGRESS	2018–10–27	$50.00
DONNELLY FOR INDIANA	2018–10–27	$100.00
DONNELLY FOR INDIANA	2018–10–27	$100.00
BREDESEN FOR SENATE	2018–10–27	$100.00
BREDESEN FOR SENATE	2018–10–27	$100.00
ROSEN FOR NEVADA	2018–10–27	$100.00
ROSEN FOR NEVADA	2018–10–27	$100.00
SINEMA FOR ARIZONA	2018–10–27	$100.00
HEIDI FOR SENATE	2018–10–27	$100.00
STACEY ABRAMS	2018–10–27	$250.00
ANDREW GILLUM	2018–10–27	$250.00
RICHARD CORDRAY	2018–10–27	$250.00
LAURA KELLY	2018–10–27	$250.00
TONY EVERS	2018–10–27	$250.00
STEVE SISOLAK	2018–10–27	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2018–10–27	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2018–10–27	$100.00
SINEMA FOR ARIZONA	2018–10–28	$100.00
HEIDI FOR SENATE	2018–10–28	$100.00

Contribution Description	Date	Amount
PHIL HERNANDEZ	2019–06–09	$250.00
JOSH KAUL	2019–06–12	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2019–06–25	$250.00
HALEY STEVENS FOR CONGRESS	2019–06–25	$250.00
TONY EVERS	2019–06–29	$250.00
HALEY STEVENS FOR CONGRESS	2019–09–11	$100.00
HALEY STEVENS FOR CONGRESS	2019–09–11	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–01–14	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–01–14	$100.00
HALEY STEVENS FOR CONGRESS	2020–06–07	$100.00
HALEY STEVENS FOR CONGRESS	2020–06–07	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–06–07	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–06–07	$100.00
MCGRATH FOR U.S. SENATE	2020–06–07	$125.00
DITCH FUND	2020–06–07	$125.00
MARK KELLY FOR SENATE	2020–06–07	$100.00
THERESA GREENFIELD FOR IOWA	2020–06–07	$100.00
DOUG JONES FOR U.S. SENATE	2020–06–07	$100.00
HICKENLOOPER FOR COLORADO	2020–06–07	$100.00
CAL FOR NC	2020–06–07	$100.00
SARA GIDEON FOR MAINE	2020–06–07	$250.00
JAIME HARRISON FOR U.S. SENATE	2020–06–07	$250.00
MONTANANS FOR BULLOCK	2020–06–07	$250.00
BIDEN FOR PRESIDENT	2020–06–07	$250.00
BIDEN FOR PRESIDENT	2020–08–27	$250.00
LAUREN UNDERWOOD FOR CONGRESS	2020–08–27	$100.00
HALEY STEVENS FOR CONGRESS	2020–08–27	$100.00
MONTANANS FOR BULLOCK	2020–08–27	$250.00
JAIME HARRISON FOR U.S. SENATE	2020–08–27	$250.00
SARA GIDEON FOR MAINE	2020–08–27	$250.00
CAL FOR NC	2020–08–27	$250.00
DOUG JONES FOR U.S. SENATE	2020–08–27	$100.00
THERESA GREENFIELD FOR IOWA	2020–08–27	$250.00

Contribution Description	Date	Amount
MARK KELLY FOR SENATE	2020–08–27	$100.00
LAUREN UNDERWOOD FOR CONGRESS	2020–08–27	$100.00
HALEY STEVENS FOR CONGRESS	2020–08–27	$100.00
AMY MCGRATH FOR SENATE, INC.	2020–08–27	$250.00
HICKENLOOPER FOR COLORADO	2020–08–27	$250.00
JON OSSOFF FOR SENATE	2020–08–27	$250.00
JON OSSOFF FOR SENATE	2020–12–06	$250.00
WARNOCK FOR GEORGIA	2020–12–06	$250.00

14. Honors and awards (list all scholarships, fellowships, honorary degrees, honorary society memberships, military medals, and any other special recognitions for outstanding service or achievement received since the age of 18):

    Brown School of Social Work Distinguished Alumni Award, Washington University: 2016.

15. Published writings (list the titles, publishers, dates, and hyperlinks (as applicable) of all books, articles, reports, blog posts, or other published materials you have written):

    None.

16. Speeches (list all formal speeches and presentations (*e.g.,* PowerPoint) you have delivered during the past 5 years which are on topics relevant to the position for which you have been nominated, including dates):

    Below is a list that covers my tenure as the Wisconsin Department of Health Services Secretary-designee. In the 3 years prior to that, I did not deliver any speeches relevant to the position for which I have been nominated.

Speech Forum	Date
CCS Spring Conference	2019–04–16
Wisconsin Assisted Living Association Conference	2019–04–30
Doctor Day Conference	2019–05–01
Wisconsin Public Health Association Conference	2019–05–23
Surgical Collaborative of Wisconsin	2019–05–29
Bx Health Budget	2019–06–06
SUD Prevention Conference	2019–06–11
Drug Endangered Children Conference	2019–07–16
Wisconsin Personal Services Association Conference	2019–09–18
Caregivers Taskforce Launch	2019–09–25
Disability Service Provider Network Conference	2019–10–17
Covering Wisconsin 211 Webinar	2019–10–21
DHS DQA FOCUS Conference	2019–11–21
LeadingAge Conference	2020–02–18
WAFCA Leadership Summit	2020–03–05

Speech Forum	Date
Rep. Gallagher Teletownhall	2020–03–26
Rep. Kind Teletownhall	2020–03–26
Rep. Kind Teletownhall	2020–06–04
Wisconsin Assisted Living Annual Conference	2020–09–17

17. Qualifications (state what, in your opinion, qualifies you to serve in the position to which you have been nominated):

I believe my public health and social services expertise and extensive health care and management experience qualify me to serve as the Deputy Secretary of the U.S. Department of Health and Human Services (HHS).

I have been in public service for the vast majority of my career, from my earliest days as a caseworker for crime victims to my time as a crisis counselor for individuals struggling with serious mental health conditions and contemplating suicide. I have broad experience in health care, behavioral health, public health, and children and families issues—working for private, non-profit organizations, as well as local, State, and Federal Government in direct service, policy-making, and administrative roles.

During my tenure at HHS during the Obama-Biden administration, I worked on the legislative formulation and implementation of major bipartisan efforts, including the Food Safety Modernization Act, the Tobacco Control Act, reauthorization of the Ryan White Act, and the 21st Century Cures Act, among others. As a member of the HHS Budget Council, I helped craft and implement each budget enacted during the Obama-Biden administration.

As the Chief of Staff at HHS, I oversaw the operations of the Secretary's office, which includes a number of offices that provide support to the work of the Department and the Department's external partners, including communications, legislative and external affairs, as well as the general counsel, budget, and administrative functions, among others. In my final role at HHS, I served as the lead for the Department's agency-wide work to stem the tide of the opioid epidemic and enact then-Vice President Biden's Cancer Moonshot Initiative.

As the Department of Health Services (DHS) Secretary-designee, I ran one of the largest State agencies in Wisconsin, with an annual budget of $12 billion and more than 6,100 employees. I was responsible for the State Medicaid program, the Supplemental Nutrition Assistance Program (SNAP), and behavioral health programs, among others. I was also responsible for the health and safety of Wisconsinites living at our seven 24/7 residential facilities. And as the public health agency for the State of Wisconsin, I led the State's response to the COVID–19 pandemic.

During my tenure as Secretary-designee, I worked with the Legislature to enact a bipartisan telehealth bill, which was fundamental to our ability to expand access to care across the State, particularly in Wisconsin's many rural communities. It was also a critical springboard for the State's ability to maintain and further expand access to care during the pandemic, particularly for behavioral health care.

I was also proud to secure bipartisan support for State funding to allow the draw-down of additional Children's Health Insurance Program dollars to support a Lead Safe Homes Initiative. Wisconsin is one of just a handful of States to take this innovative approach to address a critical public health issue for children and families.

As Secretary-designee, I launched the first-ever employee engagement effort at DHS, including an annual employee viewpoint survey to gauge the strengths of the organization and identify areas for improvement in an effort to attract and retain the best public servants at DHS.

As we tackle the COVID–19 pandemic and help the American people recover, the work of the U.S. Department of Health and Human Services has never been more important than it is right now. I believe my experiences and background qualify me for the role of Deputy Secretary, and I am honored by President Biden's nomination and ready for this responsibility. I would sincerely look for-

ward to the opportunity to work with the members of this committee, should I be confirmed.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections (including participation in future benefit arrangements) with your present employers, business firms, associations, or organizations if you are confirmed by the Senate? If not, provide details.

   Yes.

2. Do you have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, provide details.

   No.

3. Has any person or entity made a commitment or agreement to employ your services in any capacity after you leave government service? If so, provide details.

   No.

4. If you are confirmed by the Senate, do you expect to serve out your full term or until the next presidential election, whichever is applicable? If not, explain.

   Yes.

C. POTENTIAL CONFLICTS OF INTEREST

1. Indicate any current and former investments, obligations, liabilities, or other personal relationships, including spousal or family employment, which could involve potential conflicts of interest in the position to which you have been nominated.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

2. Describe any business relationship, dealing, or financial transaction which you have had during the last 10 years (prior to the date of your nomination), whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

3. Describe any activity during the past 10 years (prior to the date of your nomination) in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any legislation or affecting the administration and execution of law or public policy. Activities performed as an employee of the Federal Government need not be listed.

   In the last 2 years as Wisconsin Department of Health Services Secretary-designee, I have been involved in a number of legislative and public policy issues at the local and State level on behalf of my Department and the Evers administration. Also in this role, I have been involved in advocating at the Federal level on health policies of concern to the State of Wisconsin. Prior to that, I had no activity or was an employee of the Federal government.

4. Explain how you will resolve any potential conflict of interest, including any that are disclosed by your responses to the above items.

   Any potential conflict of interest will be resolved in accordance with the terms of my ethics agreement, which was developed in consultation with ethics officials at the Department of Health and Human Services and the Office of Government Ethics. I understand that my ethics agreement has been provided to

the committee. I am not aware of any potential conflict other than those addressed by my ethics agreement.

5. Two copies of written opinions should be provided directly to the committee by the designated agency ethics officer of the agency to which you have been nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position.

I understand that my ethics agreement has been provided to the committee.

D. LEGAL AND OTHER MATTERS

1. Have you ever been the subject of a complaint or been investigated, disciplined, or otherwise cited for a breach of ethics for unprofessional conduct before any court, administrative agency (*e.g.,* an Inspector General's office), professional association, disciplinary committee, or other ethics enforcement entity at any time? Have you ever been interviewed regarding your own conduct as part of any such inquiry or investigation? If so, provide details, regardless of the outcome.

No.

2. Have you ever been investigated, arrested, charged, or held by any Federal, State, or other law enforcement authority for a violation of any Federal, State, county, or municipal law, regulation, or ordinance, other than a minor traffic offense? Have you ever been interviewed regarding your own conduct as part of any such inquiry or investigation? If so, provide details.

No.

3. Have you ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.

I have not been involved in any administrative proceedings or civil litigation in my personal capacity. Supplemental information: In my official capacity as former Wisconsin Department of Health Services Secretary-designee, I was sometimes named in litigation.

4. Have you ever been convicted (including pleas of guilty or *nolo contendere*) of any criminal violation other than a minor traffic offense? If so, provide details.

No.

5. Please advise the committee of any additional information, favorable or unfavorable, which you feel should be considered in connection with your nomination.

N/A.

E. TESTIFYING BEFORE CONGRESS

1. If you are confirmed by the Senate, are you willing to appear and testify before any duly constituted committee of the Congress on such occasions as you may be reasonably requested to do so?

Yes.

2. If you are confirmed by the Senate, are you willing to provide such information as is requested by such committees?

Yes.

QUESTIONS SUBMITTED FOR THE RECORD TO ANDREA JOAN PALM

QUESTION SUBMITTED BY HON. RON WYDEN

RACIAL AND ETHNIC DISPARITIES WITHIN THE CHILD WELFARE SYSTEM

Question. The child welfare system is rife with racial, ethnic, and socioeconomic disparities. Black and American Indian children are over-represented in the child welfare system, and there are clear disparities that children and families of color experience when interacting with the child welfare system. As you know, the Family First Prevention Services Act (FFPSA) is groundbreaking in its support and financing of evidence-based prevention services for children and parents to help them stay safely together and thrive.

If confirmed, how will you ensure that FFPSA implementation lives up to its congressional intent?

In particular, how will you ensure the prevention services allowable under FFPSA are as inclusive and expansive as possible to ensure that there are a range of services for States and tribes to utilize that are culturally sensitive and have demonstrated positive outcomes for underserved communities, including tribal nations, black, Latinx, LGBTQ+ communities, and older, aging-out foster youth?

Answer. The Family First Prevention Services Act (FFPSA) is an important law that seeks to transform child welfare services by increasing support for evidence-based prevention services to strengthen families and keep children and youth safely at home and in their communities with their parents, other family members or kin whenever possible. If confirmed as Deputy Secretary, I will be committed to ensuring that the prevention services available are culturally appropriate and responsive to the needs of all people and communities, especially communities that have been traditionally underserved. As you know, the Biden administration and Secretary Becerra are committed to advancing racial equity and support for underserved communities, as reflected in the executive order the President signed on his first day in office, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." As Deputy Secretary, I will strive to advance this goal in all of our work.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

PROVIDER RELIEF FUND

Question. Throughout the past year, Congress has dedicated significant resources toward supporting hospitals and other health-care providers who have been negatively impacted by COVID–19. One of the largest sources of funding for provider relief has been through the Provider Relief Fund.

If confirmed, will you commit to ensuring future distributions from the provider relief fund are equitable and transparent, and prioritize funding for those providers and facilities that continue to disproportionately struggle because of the pandemic?

Answer. During the pandemic, while some providers have experienced challenges with overcapacity, many other providers have faced financial setbacks related to billing disruption, the suspension of non-essential surgeries and procedures, and health-care staff unable to work. HHS is committed to supporting providers who are taking care of patients during this pandemic and to making payments quickly while ensuring program integrity and effective oversight. If confirmed, I will work to ensure that the Provider Relief Fund is run transparently and equitably.

FDA CONSUMER PROTECTION

Question. The Food and Drug Administration (FDA) is first and foremost a consumer protection agency; however, in the past there have been times when the FDA has served as little more than a rubber stamp for industry. It is time to rebuild consumer confidence in the FDA and give the FDA the tools, resources, and authorities it needs to help protect our health and safety.

We have to be more aggressive on youth vaping and nicotine reduction. We must examine our drug supply chain and assess and correct vulnerabilities and gaps.

If confirmed, how will you work with Secretary Becerra and the FDA Commissioner to ensure the consumer, the patient, remains at the center of all of the work HHS does—including the FDA?

Answer. Patients and families should be at the heart of all of the work of HHS. It will be necessary for many agencies within HHS to work together in order to address this important issue. The work of FDA is critical for assuring consumer protections, including through tobacco regulation and ensuring the safety and security of our drug supply chain. If confirmed, I look forward to working on these issues.

BIOSIMILARS

Question. Thank you for your commitment to lowering the high cost of prescription drugs. The robust uptake of biosimilars represents an opportunity to increase competition in the prescription drug marketplace and reduce costs for patients and taxpayers. I'd like to work with you on ways to maximize the uptake of biosimilars

as they enter the market to ensure competition and reduce patient out-of-pocket cost.

If confirmed, what additional steps should and will you take to build out a robust biosimilars market and ensure all patients who require treatment have immediate access to high quality, affordable biosimilar biologic medicines?

Answer. Like President Biden and Secretary Becerra, I believe we must do all we can to lower the costs of prescription drugs and make them more accessible for Americans who depend on them. Competition in the market has helped control the growth in spending on prescription drugs. I believe that biosimilars have a role to play in containing the cost of expensive therapies by creating competition. I am committed to reducing drug prices and ensuring Americans have access to the drugs that they need. If confirmed, I look forward to working with you to find ways to achieve these important goals. I will also work across the government to address barriers to reducing drug prices.

ANTIBIOTIC RESISTANCE

Question. From the CDC to the World Health Organization, public health experts consider antibiotic resistance to be one of the top threats to global health security. The threat posed by superbugs demands swift action and a robust response.

I urge you to commit to building on the National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB) and follow through on coordinated, strategic actions to address antibiotic resistance.

What actions will you take, amidst and after this pandemic, to prioritize our Nation's fight against antibiotic resistance in addition to building out our antibiotic stewardship programs and curbing the overuse of antibiotics?

Answer. It is clear that antimicrobial resistance (AMR) must be a top public health priority, not only for the United States but around the world. Even during this time, AMR remains a top HHS priority, and if confirmed, we will continue investing in key prevention strategies like early detection and containment, infection prevention, and ensuring the appropriate use of antibiotics in the U.S. and around the world. If confirmed, I will also support efforts to develop new antibiotics to treat infections that are becoming untreatable.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

OVER-THE-COUNTER HEARING AIDS

Question. In 2017, President Trump signed into law the Over-the-Counter Hearing Aid Act, a bill that I introduced with Senator Grassley, Senator Hassan, and Senator Isakson. The bill requires the FDA to categorize certain hearing aids as over the counter (OTC). Under law, the FDA was required to issue regulations regarding OTC hearing aid safety and manufacturing by August 18, 2020—but the agency failed to issue the rules on time. As Deputy Secretary of Health and Human Services, will you commit to (1) identifying the reason(s) why the OTC hearing aid proposed rules have been delayed past their statutory deadline, (2) identifying the individual(s) responsible for developing and releasing the proposed rules, (3) requiring those individual(s) to release the proposed rules as soon as possible, and (4) requiring those individual(s) to communicate frequently with my office on the timeline for the rules' release?

Answer. Thank you for your leadership on this issue. I commit that, if confirmed, I will support FDA in its rulemaking regarding over-the-counter hearing aids and look forward to working closely with you on this issue. I recognize this is a public health priority as hearing loss can have a negative effect on communication, relationships, and other important aspects of life.

THIRD-PARTY MEDICAL DEVICE SERVICING

Question. The Food and Drug Administration is responsible for ensuring the safety of medical devices. While some medical devices are disposable and are used only once, others are used repeatedly on multiple patients. Original equipment manufacturers and third-party entities often refurbish, repair, recondition, rebuild, remarket, or remanufacture these devices to ensure that they continue to operate safely and effectively after entering the market.

Entities that perform maintenance activities are subject to different regulatory requirements depending on the type of maintenance being performed. Activities that "significantly change" the performance, safety specifications, or intended use of a device are considered "remanufacturing" activities, while activities that do not change the device are considered "servicing." FDA has committed to issuing guidance clarifying the difference between "remanufacturing" and "servicing." In a 2020 letter to me and Senator Cassidy, FDA stated that it "intends to clarify the definitions of these activities so that entities can determine in which activities they are engaged, and with which regulatory requirements they should comply." The agency said it would issue the guidance during FY2020, but it has not yet done so. As Deputy Secretary of Health and Human Services, will you commit to (1) identifying the reason(s) why this guidance has been delayed, (2) identifying the individual(s) responsible for developing and releasing that guidance, and (3) requiring those individual(s) to communicate frequently with my office on the timeline for the guidance's release?

Answer. Ensuring the appropriate consumer protections to keep patients and families safe is a top priority for the Biden-Harris administration. If confirmed, I commit to supporting FDA in their work issuing guidance related to third party medical device servicing. I recognize that this is a complicated issue and regulatory clarity is very important.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

PRIVATE INSURANCE MARKETS

Question. How do you view HHS's role in the individual market, and what reforms would you propose that could affect the types of plans offered to consumers?

Answer. The Affordable Care Act expanded critical consumer protections to millions of consumers enrolled in individual market plans across the country. HHS works together with States to make sure that consumers receive these important benefits. If confirmed, it will be a priority of mine to build on the successes of the ACA and to work with the Centers for Medicare and Medicaid Services to make sure American patients and their families continue to have access to quality, affordable health care.

MEDICAID WAIVERS

Question. What is your view of the appropriate role of incentives and disincentives in the Federal Government's partnership with State agencies?

Answer. The partnership between States and the Federal Government is central to Medicaid. I know each State—including Idaho—is unique, and innovation is critical to improving the health-care system. If confirmed, I will support State innovation and the ability of States to test different models that meet the objectives of the Medicaid program. I look forward to working with colleagues at the Centers for Medicare and Medicaid Services on this issue and to hearing morefrom you about what ideas are working in Idaho.

MEDICARE SOLVENCY

Question. Medicare is on a near-term path toward bankruptcy. The HI trust fund could be insolvent in anywhere from 4 to 5 years. Other than during the first few years of the Medicare program's existence, Congress has never allowed the HI trust fund to project less than 4 years of solvency without acting in order to minimize the impact on health-care providers, taxpayers, and beneficiaries. Given the looming fiscal crisis, how soon can we expect a comprehensive legislative proposal from HHS that extends the life of the HI trust fund?

Answer. Medicare solvency is an incredibly important, longstanding issue. I look forward to working with Congress, and in concert with the Centers for Medicare and Medicaid Services, on a bipartisan basis to address this. We will need both short-term and long-term strategies to make sure Medicare remains a bedrock of our health-care system. It is essential that we protect and strengthen this program for Americans who have spent their lives paying into it.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. The Family First Prevention Services Act allows States to receive Federal reimbursement for prevention services in order to keep children with their families whenever possible. In order to qualify for IV–E reimbursement, programs are required to be evidence-based. Currently, there are 29 programs that have been rated as promising, supported, or well-supported, and many programs are still awaiting evaluation on the Administration for Children and Families' (ACF) Clearinghouse. The COVID–19 pandemic has caused prevention service providers to alter their service models to comply with social distancing and other precautions. Additionally, some programs have faced decreased capacity or enrollment, leading to challenges in maintaining population sizes necessary for an evaluation. If confirmed, how will you work to ensure that ACF continues to add programs to the clearinghouse while maintaining the standards for evidence-based practices required by the Family First Prevention Services Act?

Answer. The Family First Prevention Services Act (FFPSA) is a law that offers the promise to transform child welfare services by increasing the availability of evidence-based prevention services to strengthen families and keep children and youth safely at home and in their communities with their parents, or kin whenever possible. If confirmed as Deputy Secretary, I will work with the leadership of ACF to ensure that the Title IV–E Prevention Services Clearinghouse has adequate resources to be able to review and rate programs in a timely manner. I will also support the continued development of evidence-based practices through support of quality evaluation.

Question. Many States, including my home State of Iowa, have faced a shortage of qualified foster parents in recent years. The COVID–19 pandemic has exacerbated these shortages in many areas. In addition to getting new foster parents involved, there is a challenge in retaining foster parents for longer than 1 year. If confirmed, how would you work to improve foster parent recruitment and retention so that children are not placed in inappropriate settings due to a lack of available foster homes?

Answer. I understand the important role that foster parents play in caring for children. As reflected in the policy goals of the Family First Prevention Services Act, when children must enter foster care, family foster homes—preferably kinship care—must be the preferred placement setting and institutional placements used only under limited circumstances. Whenever possible, child welfare systems must seek relatives and kin to care for children, to reduce the trauma children experience when they are separated from their parents. The COVID–19 pandemic has placed great strain on all parents, including foster parents and kinship caregivers, and has had an impact on the ability to train and engage prospective foster parents and support existing foster parents. I think it is essential that child welfare agencies provide adequate support to foster parents, including relative caregivers and that they be proactive in recruiting diverse families to meet the needs of children who must come into foster care. If confirmed, I will work with leaders of the Administration for Children and Families to provide support for foster parent recruitment and retention.

Question. The Adoption and Safe Families Act of 1997 required States to ensure that children in foster care did not languish in the system without permanency. It established that parental rights should be terminated if children have been in foster care for 15 out of the last 22 months. The law allows for exceptions if it is determined that there is a compelling reason that termination of parental rights is not in a child's best interest, or other limited reasons. States are not required to collect data on the enforcement of this law, and often do not provide a reason for granting an exception. If confirmed, will you work to improve oversight of this law to ensure that States are acting in the best interest of children?

Answer. When children must enter into care, it is essential that we seek to ensure timely permanency. Whenever possible we should seek to support safe and timely reunification of children with their parents or extended family, but this is not always possible. As you note, the Adoption and Safe Families Act of 1997 established time frames for the filing of petitions to terminate parental rights, but allowed for certain exceptions. If confirmed, I will work with the Administration for Children and Families to review oversight of this provision and explore any additional steps that may be needed to promote the best interests of children.

Question. In 2017, I sponsored the Over-the-Counter Hearing Aid Act with Senator Warren, which was included in the FDA Reauthorization Act of 2017. It re-

quired the Food and Drug Administration (FDA) to issue a regulation by August 2020 establishing the requirements for products in this category. This legislation was based on recommendations put forth by the Presidential Council of Advisors on Science and Technology and the National Academies of Science Engineering and Medicine to increase consumer access to hearing aid technology and decrease costs associated with hearing aids. The FDA has not completed rulemaking on this. If confirmed, will you work to prioritize rulemaking so consumers can access affordable help for hearing loss that Congress intended?

Answer. Thank you for your leadership on this issue. I commit that, if confirmed, I will support FDA in its rulemaking and work to ensure availability of over-the-counter hearing aids. I recognize this is a public health priority as hearing loss can have a negative effect on communication, relationships, and other important aspects of life.

Question. I support transparency in the 340B Drug Pricing Program. The previous administration finalized a 340B Drug Pricing Program Administrative Dispute Resolution regulation that went into effect in January 2021. This final rule sets forth the requirements and procedures for the 340B Program's administrative dispute resolution (ADR) process. The rule establishes a 340B Administrative Dispute Resolution Board to review claims. In addition, on December 30, 2020, the Department of Health and Human Services' Office of the General Counsel released an advisory opinion. If confirmed, are you committed to the continued implementation of the 340B Drug Pricing Program Administrative Dispute Resolution final rule and Office of General Counsel's advisory opinion? If confirmed, what detailed steps will the Biden administration take to ensure transparency in the 340B Drug Pricing Program?

Answer. The 340B Drug Pricing Program is an indispensable program for our safety-net providers serving some of our neediest populations. If confirmed, I look forward to working with you and other members of Congress to uphold the law and ensure this vital program is able to continue supporting vulnerable communities.

Question. During the last 2 years as chairman of the Senate Finance Committee, I've focused some of my oversight on what steps the Department of Health and Human Services has taken to detect and deter foreign threats to taxpayer-funded research. As part of my oversight, I've also worked to ensure that the Department's Office of National Security is given full, complete, and consistent access to all Intelligence Community information involving threats to the Nation's health care, such as COVID–19. That office has gained access to some Intelligence Community elements but more must be done. On March 8, 2021, I wrote a follow-up letter to the Department of Health and Human Services and the Director of National Intelligence asking what they've done to incorporate Federal health agencies into the Intelligence Community. HHS has failed to respond. If confirmed, will you commit to answering that letter in full? If confirmed, will you commit to updating me on the functions of the Office of National Security and how it's interacting within the Intelligence Community?

Answer. HHS is committed to working with Congress on its critical oversight work. As I noted in my hearing, if confirmed, I look forward to working with you on this issue.

Question. In 2020, I cosponsored the Temporary Reauthorization and Study of the Emergency Scheduling of Fentanyl Analogues Act and it was signed into law. The law extended the Drug Enforcement Administration's temporary scheduling order to proactively control deadly fentanyl analogues. Fentanyl-related overdose deaths continue to rise and sophisticated drug trafficking organizations manipulate dangerous substances to skirt the law, so this critical law placed fentanyl substances in Schedule I so that they can be better detected and criminals can be held accountable for their actions. The law sunsets in May of 2021. In December 2019, 56 other State and territory Attorneys General asked Congress to permanently codify a temporary emergency scheduling order keeping fentanyl-related substances classified as Schedule I drugs. If confirmed, do you support permanently codifying a temporary emergency scheduling order keeping fentanyl-related substances classified as Schedule I drugs?

Answer. If confirmed, I will work with you on legislation to ensure the appropriate scheduling of fentanyl and fentanyl analogues that pose a danger.

Question. Science tells us that an unborn child has many of the neural connections needed to feel pain, perhaps as early as eight weeks and most certainly by 20 weeks fetal age. Providing health care to unborn children and their mothers can

help reduce infant mortality rates in low-income communities, research also suggests. Some States already offer prenatal care and other health services to unborn children through the Medicaid program. What is your view on whether unborn children should be entitled to Medicaid coverage, and do you believe that the Federal Government has a role to play in encouraging such coverage?

Answer. Medicaid is an important source of pre- and post-natal care, and if I am confirmed, I will work to ensure access to quality pregnancy care that improves their own health and the health of their babies. I was happy to see that Congress included incentives for States to expand Medicaid postpartum coverage in the American Rescue Plan and that CMS has approved section 1115 demonstration projects to this effect. I look forward to working with members of this committee and Congress to expand access to affordable, quality care, including through the Medicaid program.

Question. Congress's ability to acquire information from Federal agencies is critical to its constitutional responsibility of conducting oversight of the executive branch. If you are confirmed, will you commit to providing thorough, complete, and timely responses to requests for information from members of this committee, including requests from members of the Minority?

Answer. If confirmed, I will provide responses to requests from any members of this committee.

Question. In 2019, Congress passed bipartisan the Advancing Care for Exceptional (ACE) Kids Act to improve health outcomes and care coordination for children with complex medical conditions in Medicaid. In 2020, I introduced the bipartisan Accelerating Kids' Access to Care Act to further help families gain access to life-saving care for children with complex medical conditions. The legislation aims to facilitate access to care while retaining program safeguards and reducing regulatory burdens on providers. If confirmed, what steps would you take to improve the system of care for children with complex medical conditions?

Answer. Thank you for your leadership on the ACE Kids Act and your focus on access to care for children with complex medical needs. I agree that we should do all we can to remove barriers to care for these children. If I am fortunate enough to be confirmed, I will look forward to working with you on solutions to ensure children with complex medical needs get the best care possible.

Question. In Iowa, transitional health plans (including grandmothered health plans) have enabled many middle-class Iowans to keep the health plans and doctors they like at a reasonable price since the Affordable Care Act was implemented. For example, over 56,000 Iowans are covered by grandmothered health plans. To put this in context, about 60,000 Iowans signed up for the Federal health insurance exchange in 2021. Iowans have chosen these grandmothered health plans that meet their individual needs. Currently, grandmothered health plans' existence is determined by the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS) annually through non-enforcement extensions. If confirmed, are you committed to maintaining these affordable, consumer-chosen health plan options for Iowans by extending the non-enforcement authority?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine rules and other policies to ensure all Americans can access the care that they need.

Question. Since this COVID–19 pandemic began, the Department of Health and Human Services (HHS) including within the Centers for Medicare and Medicaid Services (CMS) has provided health-care providers and patients many flexibilities under the public health emergency authority including over 80 services now furnished through telehealth for Medicare patients. A Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report found the use of telehealth increased 154 percent during the last week of March 2020 during the emergency of COVID–19 compared to the same period in 2019. We know the use of telehealth has continued throughout the COVID–19 pandemic. The data and response from patients and providers prove permitting telehealth services is a positive action to improve access and care. This last Congress, we provided permanent coverage for mental health telehealth visits under Medicare, which is helpful during the pandemic and will remain critical for many Americans afterwards. If confirmed, are you committed to working with Congress and in the executive branch to extend telehealth flexibilities in Medicare beyond the pandemic? Additionally, some providers, including community health centers, face regulatory barriers based on provider type

or site of service. If confirmed, do you support removing those telehealth barriers for certain providers?

Answer. Telehealth is an important tool to improve health equity and access to health care. Health care should be accessible, no matter where you live. If confirmed, I would look forward to working with you and my colleagues at the Centers for Medicare and Medicaid Services on this issue.

Question. As a direct result of the Affordable Care Act's one-size-fits-all approach, many Iowans have been priced out of health insurance. To rectify this, the Trump administration and Iowa Insurance Division enabled Iowans more choice and competition in the health-care marketplace by enabling and expanding short-term limited-duration insurance (STLDI). This gives Iowans access to health insurance with consumer protections. If confirmed, will you work to maintain, modify, or rescind the current regulations enabling Americans to purchase STLDIs?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine rules and other policies to ensure that plans provide Americans access to the care that they need.

Question. It is important to give people affordable options for health insurance. Small business owners, like Iowa farmers, want to be able to provide insurance for their employees. Association Health Plans are a way for these small businesses to band together to expand access to health insurance and drive down costs. I have introduced legislation and support efforts to expand the pathway to affordable and accessible health care remaining open to employees across America. Association Health Plans allow small businesses to join together to obtain affordable health insurance as though they were a single large employer. The coverage offered to association members is subject to the consumer protection requirements that apply to the nearly 160 million Americans who receive coverage from large employers. If confirmed, will you work to maintain, modify, or rescind current regulations enabling employers and employees access to Association Health Plans?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine all rules and policies to ensure all Americans can access the care that they need.

Question. I support access to affordable health-care coverage for all Iowans, regardless of their health status or pre-existing conditions. Americans want to be in control of their own health care. National, single-payer health systems do not allow that. The Affordable Care Act took options away from people and adopting a single-payer system will make that worse. A national, single-payer health system would eliminate private health insurance for nearly 200 million Americans and require middle-class Americans to pay much more in taxes. Single-payer health care would also dramatically increase government spending substantially, fail to meet patient needs quickly, reduce provider payments rates and reduce quality of care, and the government would have more control over health care. It also threatens the benefits that current seniors on Medicare have paid into the system their entire working lives. If confirmed, do you intend to take administrative actions to implement the vision of a one-size-fits-all government-run health-care scheme like single-payer? If so, please describe what authority you believe you have to take such actions?

Answer. President Biden has made it very clear that his goals for improving the American health-care system begin with building on the successes of the Affordable Care Act, and I am committed to working toward that goal.

Question. If confirmed, will you take actions that stifle innovation and competition in health care?

Answer. I believe it is important to foster innovation and competition in our health-care system. Americans should have access to health-care services and products at an affordable price.

Question. In 2019, the Trump administration issued two rules requiring price transparency for hospitals and health plans. The rules took effect in January 2021. This effort shines a light on the health-care industry that is all too often shrouded in secrecy. While Congress can build upon the rules, consumers can finally see sunshine in health-care pricing. I have cosponsored legislation to codify the two health-care price transparency rules. This transparency will bring more accountability and competition to the health-care industry. Consumers should have the ability to compare health-care prices online so they can make an informed choice about what's

best for them and their families. If confirmed will you modify, rescind, or maintain the Trump administration's health-care price transparency regulations?

Answer. If I am fortunate enough to be confirmed, I will ensure that the Department continues to take steps to improve price transparency, so consumers can look behind the curtain to understand how providers and insurers are operating.

Question. Some States have lacked transparency in reporting their nursing home COVID–19 deaths data. For example, the State of New York undercounted nursing home deaths by as much as 50 percent and State officials intentionally withheld data for months. The New York Attorney General Letitia James released a report in January 2021 suggesting that many nursing home residents died from COVID–19 in hospitals after being transferred from their nursing homes. These figures were not reflected in the New York Department of Health's nursing home death figures for many months suggesting the State was undercounting by as much as 50 percent. There are also reports finding New York State officials including members of New York Governor Andrew Cuomo's staff intentionally withheld data on COVID–19-related deaths in the State's nursing homes. Following the release of the New York Attorney General report, the New York Department of Health reported 12,743 nursing home residents occurred. This included an additional 3,829 confirmed COVID–19 fatalities of those residents who had been transported to hospitals. I have warned President Biden that an across-the-board termination of 56 U.S. attorneys could imperil ongoing sensitive investigations. This concern has been expressed by Senate Democrats. Currently, Toni Bacon is serving as the U.S. attorney for the Northern District of New York. Ms. Bacon previously served as Justice Department's national elder justice coordinator and who currently has jurisdiction over Federal public corruption crimes in the State. Bacon is the obvious choice to continue a fair and unbiased investigation into possible violations of civil liberties of the elderly and the public corruption. Do you believe Department of Justice must have a fair, unbiased, and experienced U.S. Attorney in the Northern District of New York, such as Ms. Bacon?

Answer. I defer to the Department of Justice on the selection of U.S. attorneys.

Question. I led an effort in the Senate making additional resources available to support elder justice initiatives that assist older Americans especially throughout the COVID–19 pandemic. During the 116th Congress, as Senate Finance Committee chairman, I convened two hearings on elder justice initiatives and gaps in nursing home oversight. In December 2020, I urged Senate leadership to make resources available for regional or statewide strike teams to support nursing homes in crisis during this pandemic. Through this work, the end-of-year COVID–19 relief package included $100 million to support elder justice initiatives, including $50 million for State adult protective service agencies as they cope with unique challenges of serving vulnerable populations during the pandemic. This work includes nursing home strike teams who have provided needed support when an outbreak occurs at a nursing home or when additional resources are needed to meet the infection control or diagnostic testing requirements. Have State or Federal nursing home strike teams been effective at controlling outbreaks and protecting vulnerable Americans? If so, can you describe how their work slowed the spread and protected lives?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has hit the Nation's nursing homes. Nursing homes and long-term care facilities are the homes for some of our most vulnerable, and we must do everything we can to work to protect them and ensure that they are receiving high quality health care. In Wisconsin, we developed a variety of strategies, including surging staff and other resources to assist our skilled nursing facilities protect their residents from COVID–19. If I have the honor of being confirmed, I look forward to working on this issue and coordinating with the Centers for Medicare and Medicaid Services.

Question. The global pandemic has exposed grave concerns our society must confront to protect the Nation's most vulnerable citizens. Approximately 1.4 million Americans live in about 15,000 nursing homes across the country. Many Iowans have a loved one who lives in a long-term care facility. In 2019, as chairman of the Senate Finance Committee, I conducted a series of hearings to examine gaps in enforcement of nursing home abuse. A Government Accountability Office (GAO) investigation found a 103-percent increase in abuse deficiencies between 2013 and 2017. The GAO noted abuse in nursing homes is often underreported. The report documented physical, mental, verbal, and sexual abuse perpetrated against residents. The number of nursing home deaths attributed to COVID–19 delivers a wake-up call we can't afford to ignore. The Federal Government needs to do a better job enforcing compliance with standards of care. When a loved one requires a long-term

care facility to deliver around-the-clock services, every family deserves peace of mind that every nursing home resident will receive high-quality, compassionate care and be treated with dignity and respect. If confirmed, how will you, as Deputy Secretary, ensure nursing homes uphold the standard of care that is necessary while not placing onerous requirements and excessive administrative burdens on nursing home staff?

Answer. Thank you for your longstanding leadership on this issue. Nursing homes and long-term care facilities are the homes for some of our most vulnerable, and we must do everything we can to work to protect them. If I have the honor of being confirmed, I look forward to coordinating with colleagues at the Centers for Medicare and Medicaid Services to improve the safety and quality of care for residents of nursing homes.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

FOREIGN THREATS TO RESEARCH

Question. Ms. Palm, in 2019, this committee held a hearing on foreign threats to taxpayer-funded research after multiple reports of espionage by the People's Republic of China. We have seen attempts by foreign entities like North Korea to steal intellectual property related to COVID vaccine development and I continue to hear concerns from research institutions in Texas.

Do you believe that NIH and other funders of public research should consider cybersecurity protocols that institutions have in place when evaluating applications for research grant funds?

What additional initiatives are you considering to ensure taxpayer funded research is protected from foreign threats?

Answer. Protecting the integrity of taxpayer funded biomedical research is a matter of great importance. I am committed to working with Congress, the NIH, and the HHS Office of National Security to ensure appropriate safeguards are in place to enhance and protect the security and the integrity of U.S. biomedical research.

SUPPLY CHAIN

Question. Regarding further distribution of personal protective equipment (PPE) and COVID–19 vaccines and ancillary products, how will government coordination with the private sector be managed? How will updates and information be communicated to the healthcare supply chain in a timely manner?

Answer. The global pandemic has highlighted the vulnerabilities of the health-care supply chain for many products. In order to continue responding to the COVID–19 pandemic and better prepare the Federal Government to respond to any future public health emergencies, it is critical that HHS work to improve and expand health-care supply chain capabilities. If confirmed, I'm committed to working in coordination with the private sector on this urgent matter.

Question. How does the new administration plan to coordinate with and leverage the expertise of the commercial healthcare supply chain to get product the last mile and get supplies into providers' hands across the care continuum?

Answer. Coordination across departments, agencies, and industries is key to ensure the adequacy of the health-care supply chain. If confirmed, I'm committed to working on this urgent matter.

Question. Once the COVID–19 pandemic is under control, how do you anticipate partnering with the commercial supply chain to ensure that the country is ready for the next public health emergency? Have you considered solutions such as a "vendor managed inventory" solution to help guarantee that non-expired product could be available on demand?

Answer. As the Nation continues to turn the corner on the COVID–19 pandemic, it is important to think ahead to the next public health emergency. If confirmed, I will work with the Assistant Secretary of Preparedness and Response (ASPR) to ensure these efforts can increase the Nation's ability to meet demand in future crises.

Question. How does the Biden administration intend to use the DPA authority and will the administration do so with thoughtful consideration of those with exper-

tise in the medical supply chain so the existing infrastructure and supply are augmented rather than duplicated?

Answer. If confirmed, I commit to working closely with members of this committee on efforts related to the COVID–19 response, including the use of Defense Production Act and its potential impacts.

HOSPICE

Question. Within the Medicare program, State survey agencies (SAs) are overburdened and often lack the capacity to respond to survey complaints in a timely and appropriate manner. The ability to respond to and correct issues arising from complaints is imperative, particularly for terminally ill beneficiaries in hospice. Accreditation Organizations (AOs) are also authorized to conduct complaint surveys. Expanding the use of qualified AOs that are trained in hospice would alleviate State regulatory burden, while continuing to ensure that all complaints are addressed in timely coordination with the SAs and CMS. The expanded use of AOs would lead to increased transparency and emphasize savings in the hospice community.

How does the administration plan to emphasize the services of Accreditation Organizations for hospice complaint surveys to relieve State regulatory burden and improve timely beneficiary safety and quality?

Answer. Improving the safety and quality of care for American patients is critical, including in hospice settings. If confirmed I will work with my colleagues in the Centers for Medicare and Medicaid Services to make sure complaints are followed up on in a timely manner.

Question. The Hospice Act brought attention to the need for Medicare surveyors, who are often State surveyors, to specifically be trained for the hospice population. Similar gaps in knowledge and judgement occur among the medical reviewers for OIG, MAC and Program Integrity hospice audits often driven by a similar hospice knowledge gap and compounded by a chart review that can never replicate the hospice program physician's real time medical prognostication of the patients at the end of life. When payment denials are appealed by the hospice provider, most are overturned on appeal, an expensive and time-consuming process for both hospices and HHS.

I understand the need for program integrity, but we cannot place so much of a burden that it creates an issue for providers that could turn into an access issue for these vulnerable beneficiaries. How will HHS address the gap in knowledge of Medicare medical reviewers, who frequently look past the certifying physician's medical judgment as reflected on the Certification of Terminal Illness (CTI); perhaps especially when the physician record entries as to the basis for prognostication are not as detailed as the Medicare reviewer believes was warranted.

Answer. Thank you for bringing up this issue. If confirmed, I certainly want to look for any ways to be more efficient and improve processes, and I will work with my colleagues at the Centers for Medicare and Medicaid Services to find ways to improve the Medicare program.

CHILDREN'S HEALTH

Question. As HHS Secretary, you will oversee a number of programs and agencies important to children from health coverage programs vital to children's health such as Medicaid and the Children's Health Insurance Program (CHIP) to programs responsible for training the pediatric health-care workforce like the Children's Hospital Graduate Medical Education Program (CHGME) to pediatric research initiatives at the National Institutes of Health.

What are your priorities for child health if confirmed?

Answer. Programs such as Medicaid and the Children's Health Insurance Program (CHIP) are critical programs that help ensure that children have adequate access to quality health care. If confirmed, I would work to ensure children are receiving necessary health care through both programs. I would also look to better ensure access to oral health and vision care for children, as both are necessary for children to thrive in school. And we cannot forget that improving child health begins with ensuring maternal health. I will work tirelessly to reduce maternal and infant mortality and morbidity, using the expertise and resources across HHS.

Further, many other agencies of HHS work improve the lives of children in matters beyond that of health-care coverage. For example, the Children's Bureau partners with Federal, State, tribal, and local agencies to improve the overall health and

well-being of our Nation's children and families. I look forward to working with Congress, and with State and local partners to make sure that we are doing all we can to improve child health in this country.

Question. Medicaid and CHIP are critical programs for children, providing coverage for over 40 million children. Medicaid is also the backbone of the pediatric health-care system providing care across the continuum from screenings and preventive to highly specialized diagnoses and treatments.

What are your plans to strengthen this safety net for children and the providers who care for them?

Answer. If confirmed, I would work to support and strengthen Medicaid and CHIP, as well as other programs for children, to ensure that children have adequate access to quality health care. In particular, I would look to better ensure access to oral health and vision care for children, while working to reduce maternal and infant mortality and morbidity, as well as programs that ensure the safety of well-being for children and families. If confirmed, I lookforward to working with you to make sure our children have access to quality care and are able to thrive.

Question. The pandemic is having a profound impact on children's health and the providers who care for them.

What are your immediate plans to address the current crisis in the increasing number of children facing severe mental, emotional and behavioral health challenges due to social isolation and the serious impact of the pandemic on the health of their families and caregivers?

Answer. I am deeply concerned about the impact of the COVID–19 pandemic on the mental, emotional, and other behavioral health outcomes of our children, their families and caregivers. I agree this must be an urgent national priority. If confirmed, I commit to working on this issue and I would seek to ensure collaboration across HHS agencies, including CMS and SAMHSA, to ensure we are fully leveraging CHIP and Medicaid, and that we do a better job of tackling this important issue.

Question. The pediatric health-care safety net has been affected by the pandemic in different ways then the adult health-care system, with less direct Federal financial support because they are not eligible for Medicare funding streams. What are your plans to sustain a stable pediatric health-care system now and beyond the pandemic?

Answer. Medicaid and CHIP are lifelines to children and help form the fabric of the pediatric health-care safety net. Over 77 million individuals are enrolled in those programs, and about half are children. It is critical that we work to support our pediatric health-care safety net and pediatric health-care providers during the COVID–19 pandemic and beyond. If confirmed, I would make it a priority to work across HHS and with States to provide necessary support to pediatric providers.

Question. The Children's Hospital Graduate Medical Education Program (CHGME) provides significant support for the training of pediatricians and pediatric specialists. But unfortunately, the funding for this program still lags far behind the Medicare GME program—funding only half of what Medicare GME provides per resident.

What are your plans to address this gap in training support for our Nation's pediatric workforce?

Answer. If confirmed, I would work with the resources across the Department and with States to support the health-care workforce, including those who work with pediatric populations.

Question. During the pandemic, telehealth has played a major role in providing access to care for Medicaid beneficiaries, including children.

How will HHS support the continued use and enhancements needed under Medicaid to ensure telehealth continues to enable access to care for children?

Answer. Telehealth is an important tool to improve health equity and improve access to health care. Health care should be accessible, no matter where you live. Under current law, States have a great deal of flexibility with respect to delivering Medicaid services via telehealth. Medicaid has made great strides in expanding services available through telehealth, including pediatric services, during the public health emergency. If confirmed, I will work with CMS to determine how we can

build on this work to improve health equity and improve access to health care for children.

Question. As you know, pediatric health care is organized differently than adult health care. Pediatric care is more regionalized and often results in children, especially those with complex health needs, having to travel across State lines for care. Under Medicaid, this can be challenging for them and their providers with different policies State to State. The ACE Kids Act passed in 2019 and is effective next year, is one step in addressing these inconsistencies and getting much needed national data to inform care improvements.

If confirmed, how would you approach these cross-State challenges that children with complex needs face when traveling for needed care?

Answer. Medicaid and CHIP are crucial to ensuring children have adequate access to quality health care, especially those with complex needs. If confirmed, I will work closely with CMS as well as across the Department to ensure children are receiving necessary health care. I look forward to working across the administration and with Congress to make informed decisions that address the specific needs of children with complex medical conditions.

Question. 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. At times, Medicare policies designed with the elderly population in mind have been applied to Medicaid or adopted by State Medicaid programs and private payers.

As you look at health-care changes at the national level as HHS Secretary, how will you ensure that children's unique health-care needs are taken into account?

Answer. If confirmed, I will work with Congress and States to spur and encourage innovation in these important programs. Innovative delivery system and payment models are vital to ensuring that Medicaid and CHIP are equipped to address emerging pediatric health issues and can continue to provide children with access to quality health care.

Question. A major focus in health care among policy makers has been on pursuing delivery system reforms that improve quality and reduce costs. The Federal Government has traditionally focused more on adult populations rather than the needs of children in these reforms. As a result, Medicaid for children still lags behind Medicare in supporting improvements in care and innovative payment models.

What steps will you take to promote increased emphasis on these types of innovations in Medicaid targeting the unique needs of children?

Answer. If confirmed, I will work with Congress and States to spur and encourage innovation in these important programs. Innovative delivery system and payment models are vital to ensuring that Medicaid and CHIP are equipped to address emerging pediatric health issues and can continue to provide children with access to quality health care.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

COUNTERMEASURE DEVELOPMENT

Question. Platform technologies or innovative delivery platforms, such as a vaccine or therapeutic administered through a patch, that can deliver medicine to patients in certain circumstances, provide promising alternatives to traditional medical treatments. These platform technologies could provide a way to deliver vaccinations to patients. An innovation that provides a vaccine dose through a patch platform could replace or provide an alternative to vaccines injected via needles. A patch delivery platform does not need to be frozen, may require less ancillary medical supplies, and could be self-administered at home. If these characteristics were in place for a countermeasure, public health and health-care organizations could distribute vaccine or therapeutic doses more widely, improving access to underserved or hard to reach communities.

How will this administration support the development of alternative delivery platforms for vaccines and other countermeasures, such as shelf-stable, self-applied patches during COVID–19?

How will this administration support expanding the use of alternative vaccine delivery platforms for future pandemic needs?

Answer. I agree that we must do all we can to improve vaccine technology and make vaccines easier to deliver. If confirmed, I will work with NIH and FDA, as well as our international partners, to ensure we take any steps needed to help facilitate the development, review, and approval of new vaccine technologies.

SYNTHETIC BIOLOGY

Question. President Biden, in his remarks on the American Jobs Plan, stated "China . . . is racing ahead of us in the investments they have in the future." Synthetic biology is an emerging field which, with the appropriate regulatory oversight and investment, has the potential to provide high-paying U.S. jobs and supply chain security. How will HHS encourage the development of synthetic biology and appropriately evaluate the evolving science to ensure a regulatory approach that does not hamper innovation?

Answer. Synthetic biology is an important, growing field and, if confirmed, I look forward working across HHS to support U.S. leadership in this space.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Over 2 months ago, my staff requested certain documents from the Department of Health and Human Services commonly referred to by the previous administration as "weekly draw down reports." These reports provide some insight into the allocation of Federal funding and subsequent spending by the States as it relates to COVID–19 supplemental appropriations. It is my understanding that these reports have been shared with other members of this chamber and are generally used for press inquiries. However, to date, my office has not received these reports despite repeated follow-ups with multiple staff members in the Department.

I think we can both agree that transparency is a good thing—particularly when it involves trillions of taxpayer dollars. If you are confirmed, will you commit to making public the funding appropriated, obligated, and spent on COVID–19 relief in a manner that is easily accessible and understood by the general public? Further, will you commit to providing weekly draw down reports with Congress on a weekly basis?

Answer. If confirmed, I commit to reviewing your request and providing this committee with information relevant to its oversight functions.

Question. During your time as Secretary-designee, on multiple occasions you attempted to bypass the Wisconsin State legislature or exceeded your authority to extend State-wide stay-at-home orders during the COVID–19 pandemic. In May 2020, the Wisconsin Supreme Court struck down Emergency Order #28 because you exceeded your statutory authority and you did not follow statutory emergency rulemaking procedures established by the State legislature. This order would have extended a previous executive order which confined all people to their homes, forbid travel, and closed businesses, but it also went a step further by establishing a criminal penalty for violators. Many months later, on October 6, 2020, you signed another emergency order to limit the number of people in certain public indoor businesses and private gatherings. The order would have also implemented a fine for violators. At a press conference on the same day, you even encouraged local governments to go further and offer more restrictive orders. The non-partisan Wisconsin Legislative Reference Bureau (WLRB) reviewed this order and determined it needed to be promulgated as a rule. A lawsuit was subsequently filed by the Wisconsin Tavern League on October 12, 2020, arguing that you once again exceeded your statutory authority and did not follow emergency rule making procedures established by the State legislature. On April 14, 2020, the Wisconsin Supreme Court ruled the emergency order violated State law and was not validly enacted.

If confirmed, how can I be assured of your compliance with Federal laws even if those laws are not popular within your own political party? Further, do you commit to abiding by the Administrative Procedure Act when enacting rules and regulations?

Answer. If confirmed, I will follow the law.

Question. Nearly 120,000 children enrolled in Medicaid across the Appalachian region received at least one opioid prescription in 2018. In some States, the share of

child beneficiaries receiving at least one prescription opioid outpaced that of adult beneficiaries. This reckless prescribing puts Medicaid beneficiaries at risk of misuse and overdose. Despite research demonstrating nonfatal overdoses are among the most significant predictors of a future overdose, the Medicaid program has persistently failed to help enrollees in these circumstances. In fact, a study of 3,606 Medicaid enrolled adolescents (ages 13–22) who experienced an opioid-related overdose found that only one in 54 received medication-assisted treatment, and less than one in three received any treatment whatsoever. Equally concerning, Medicaid beneficiaries often receive a legal opioid prescription even after suffering a nonfatal, opioid-related overdose.

Senator Joe Manchin (D–WV) and I will be reintroducing the IMPROVE Addiction Care Act this Congress. This legislation fixes a problem in the Medicaid program that fails to identify victims of previous overdoses and ensure prescribers are notified of their patients' fatal overdoses. Our legislation is supported by a handful of advocacy and provider groups including Shatterproof, Faces and Voices of Recovery and the American Society of Addiction Medicine (to name a few).

In your previous role as Secretary-designee, what efficiencies did you bring to Wisconsin's Medicaid program that directly benefited individuals suffering from substance use disorder (SUD)? How did you reduce the silos associated with their care to help connect enrollees to SUD treatment? Please be specific.

Answer. This was a crisis before the pandemic. And now we know COVID–19 has taken a toll on Americans in so many different ways. Like President Biden, I am committed to addressing the substance use disorder epidemic and to making sure patients have access to prevention, treatment, and recovery services. In Wisconsin, I was proud to work with Republicans in the State legislature to enact telehealth legislation, that among other things, improved access to substance use disorder treatment in rural and underserved communities. In addition, we launched a hub and spoke model to better integrate behavioral health treatment within health care to reduce barriers to care, break down silos and better coordinate care for Medicaid beneficiaries. If I have the honor of being confirmed, I look forward to partnering with you to continue to work on this important issue.

Question. In your testimony, you highlight bipartisan work in your role at the Department of Health and Human Services under the Obama administration. However, it does not specify bipartisan work performed in your most recent role at as Secretary-designee.

What were some of your bipartisan accomplishments with the Republican-controlled State legislature in Wisconsin? What major compromises have you had to make in order to improve Wisconsin's health-care system? Please be specific.

Answer. I am proud of the work I was able to accomplish in Wisconsin. There, we secured bipartisan expansion and modernization of telehealth in the Medicaid program and bipartisan policy changes to Wisconsin's Children's Health Insurance Program (CHIP). We also worked in a bipartisan work manner to integrate a hub and spoke model of behavioral health treatment and stand up a residential treatment benefit—both of these initiatives improved access to substance use disorder treatment in Wisconsin. In all of my work, I prioritized judicious use of taxpayer dollars and working with members of both parties to improve health care for Wisconsin families.

Question. In your testimony, you highlight reducing "the cost of prescription drugs" as one of your public health priorities.

What policies do you support to reduce the cost of prescription drugs?

Answer. I believe we must do all we can to lower the costs of prescription drugs and make them more accessible for Americans who depend on them. I am committed to finding ways to reduce drug prices and ensure Americans have access to the drugs that they need. If confirmed as Deputy Secretary of HHS, I look forward to working with you and others in Congress to achieve these important goals. I will also work across the government to address barriers to reducing drug prices.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

ON RELIGIOUS LIBERTY, LOCKDOWN ORDERS, AND REOPENING SCHOOLS

Question. During your nomination hearing, you framed your priorities as part of a "common-ground agenda." I appreciate this approach, and if you are confirmed, I look forward to working with you to advance a number of your stated goals, including, most immediately, a robust scale-up in vaccinations. Bipartisan collaboration has tremendous value as we seek to end the pandemic, bolster our economy, and increase access to health care. That said, some of my constituents have expressed serious concerns with your nomination, primarily focused on two key issues.

First, with respect to religious liberty, you faced substantial pushback from conservatives and pro-life advocates during your tenure at Wisconsin's health department, based in part on your selection of a longtime Planned Parenthood lobbyist to serve as your deputy, as well as what some Wisconsin lawmakers have described as vague or noncommittal responses around the use of public funds for abortion. Early in the pandemic, a number of State legislators also took issue with the ability of abortion clinics to continue operating and using needed medical supplies, even as countless entities across the State were forced to shutter under your shelter-in-place order. Many South Carolinians have cited these controversies as significant cause for concern, particularly given HHS's role in overseeing a broad range of programs with profound implications for religious liberty and human life.

Since long before I came to Congress, I have prioritized protections for religious liberty and freedom of conscience, one of our core constitutional rights. I have also been a committed defender of all human life, including the lives of the unborn.

Prior to taking any actions with implications for people of faith, can you commit to consulting and engaging with religious liberty advocates, including those who disagree with your previously stated positions on the issues above?

If confirmed, can you commit, through all of your actions as Deputy Secretary of HHS, to uphold religious liberty and freedom of conscience for all Americans, including those with deeply held religious convictions and beliefs?

Answer. If confirmed, I commit to thoroughly consulting stakeholders and a diverse set of voices on all relevant issues. If confirmed, I will follow the law.

Question. I have also heard from constituents across the Palmetto State with concerns regarding the shelter-in-place order that you issued in Wisconsin on April 16th of last year, which many have described as overreaching and arbitrary. In addition to banning non-essential travel, extending a sweeping shutdown of diverse businesses, and placing severe restrictions on gatherings, the order in question adopted steep penalties for violations, with fines of $250 and imprisonment of up to 30 days on the table. The Wisconsin Supreme Court majority agreed with the order's critics, with Justice Roggensack writing, in enjoining the order, "Rule-making exists precisely to ensure that kind of controlling, subjective judgment asserted by one unelected official, Palm, is not imposed on Wisconsin." The court's ruling caught the attention of *The Wall Street Journal*'s editorial board, which celebrated the decision in an op-ed entitled "Democracy Lives in Wisconsin," concluding that "[d]emocracy and the rule of law don't end because there's a pandemic."

You were not alone, particularly among blue-State officials, in issuing and extending far-reaching lockdown orders, and the tumultuous early days of the pandemic triggered a number of bold decisions across the Nation, many of which look more rash or counterproductive in retrospect than they might have appeared at the time. At the same time, lockdowns have led to dire consequences for scores of Americans, particularly in the case of vulnerable communities. We have seen unprecedented learning losses for young people, along with spikes in suicide, deaths of despair, and economic insecurity.

As you reflect on the past year, what are some of the areas where you might, in retrospect, have revised your approach to pandemic response, and what would you cite as some of the lessons learned?

In a letter to the chairman and ranking member, two members of the House who served in Wisconsin's State government during your time as Secretary-designate alleged that you "played a central role in the shuttering of Wisconsin schools for the final months of the 2019–2020 school year and led many throughout the State to operate in a hybrid or virtual learning model for 2020–2021." How would you respond to these claims, and what steps do you believe that HHS should take, in con-

cert with other Federal agencies and with State and local authorities, to accelerate the reopening of K–12 schools for in-person learning?

Answer. I am proud of the work I was able to accomplish in Wisconsin. Every single day, I got up and worked tirelessly to protect the health and well-being of the people of Wisconsin, especially as we navigated a public health crisis. If confirmed, I commit to working with the CDC and State and local leaders to ensure everyone has the resources and support necessary to ensure children nationwide are able to attend school safely, which is a top priority of the Biden administration.

ON VACCINE TECHNOLOGY INNOVATION

Question. Vaccine patches represent a promising alternative to traditional vaccines injected via needles. Vaccine patches do not need to be frozen, do not use needles, are single-dose, and can be self-administered at home. By reducing logistical challenge, wastage, and vaccine hesitancy, they could play a major role in improving our Nation's response to the COVID–19 pandemic, as well as our preparedness for future pandemics.

How will this administration support the development of alternative vaccine platforms, such as shelf-stable, self-applied patches?

How will this administration support the expansion of use of alternative vaccine platforms for future pandemic needs?

Answer. I agree that we must do all we can to improve vaccine technology and make vaccines easier to deliver. If confirmed, I will work with NIH and FDA, as well as our international partners, to ensure we take any steps needed to help facilitate the development, review, and approval of new vaccine technologies.

ON SUPPLY CHAIN RESILIENCY

Question. President Biden, in his remarks on the American Job Plan, stated "China is racing ahead of us in the investments they have in the future." Synthetic biology is an emerging field which, with the proper regulatory regime and investment, will provide high-paying U.S. jobs and supply chain security.

What legislative steps should Congress take to facilitate HHS development and support for the U.S. synthetic biology industry?

Answer. I agree that synthetic biology is an area where the U.S. needs to be the world's leader. I commit to work with you to determine what legislative or resource needs there may be at HHS to help make this a reality.

ON SUPPORT FOR NURSING HOME I–SNPS

Question. As you know, Institutional Special Needs Plans (I–SNPs) are a type of Medicare Advantage plan where the only beneficiaries enrolled are seniors living in nursing homes. When nursing homes offer these plans, they are 100 percent at risk for all the care their residents need, either at their facilities or elsewhere. In the push towards value-based care, nursing homes taking on risk via I–SNPs are doing exactly what we want to see, but in 2020, being 100 percent at risk for a population exclusively made up of the individuals most vulnerable to COVID–19, and most likely to need high-cost hospitalization, created serious financial challenges for nursing homes with I–SNPs, including numerous communities in South Carolina. While nursing homes in general have received funds from the Provider Relief Fund (PRF), neither HHS nor CMS has provided relief to address the specific challenges nursing home I–SNPs have faced in order to ensure this model's continued viability.

Will you commit to using administrative authority to support I–SNPs and to recognize the significant increased and unexpected costs that these plans have faced during the COVID–19 emergency?

Answer. It has been heartbreaking to see how hard the COVID–19 pandemic has affected the Nation's nursing home residents. Nursing home care will absolutely be a focus of mine if confirmed. Medicare Advantage serves millions of Americans, and I understand that Institutional Special Needs Plans provide important options for people in need of the level of care provided in nursing homes and long-term care facilities. If I have the honor of being confirmed as Deputy Secretary, I will be happy to work on this issue along with my colleagues at the Centers for Medicare and Medicaid Services.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. I am concerned regarding inequities in the distribution of the Provider Relief Fund. Assisted living providers care for the population most vulnerable to COVID, yet have received far too little relief to date. In my State of Oklahoma, assisted living providers care for over 18,000 seniors in 194 facilities across the State. Unfortunately, assisted living providers were allocated less than 2 percent of the Provider Relief Fund (about $3 billion dollars) and have only received about a third of that. The average age of a resident in assisted living is 85. According to the CDC, this age group is 630 times more likely to die from COVID than a 29-year-old. In assisted living, these vulnerable individuals need assistance with daily activities such as eating, using the restroom, taking medications, and dressing. Social distancing by their caregivers is not possible. Over 40 percent of assisted living residents have Alzheimer's or some form of dementia. Due to PPE needs, workforce needs and occupancy declines, assisted living caregivers have incurred over $15 billion in losses. In Oklahoma, assisted living caregivers have suffered over $235 million in losses. Now, over half of assisted living facilities Nation-wide are operating at a loss, and 56 percent say they will not be able to sustain operations for another year.

I recently signed a letter asking HHS Secretary Becerra to distribute more of the remaining PRF to assisted living facilities.

Since you may be overseeing this distribution as well, will you commit to working with all long-term care providers to ensure our Nation's most vulnerable are properly cared for?

Answer. If confirmed, I commit to working with all of our Nation's front-line workers to ensure they receive the support and resources they need to care for those who rely on them.

Question. I know that your home State of Wisconsin has some similarities to my State of Oklahoma in that we were both hit exceptionally hard by the opioid epidemic.

Please detail some of the solutions you will work on, if confirmed, to continue to combat the opioid epidemic.

Answer. HHS has worked aggressively to address our Nation's opioid epidemic. Progress was being made to increase access to evidence-based treatment and reduced death by overdose until the pandemic hit. If confirmed, I will direct HHS agencies, including SAMHSA, HRSA, AHRQ, CDC, CMS, NIH, FDA and IHS, to work together and with ONDCP and other White House components, as well as with DOJ and other Federal entities, including VA and DOD, to increase access to prevention, early intervention, treatment, and recovery support programs. People with addiction to these powerful and tenacious drugs deserve access to the full range of evidence-based prevention, early intervention, treatment and ongoing recovery supports. Substance use is a treatable condition. Through access to evidence-based programs, people can and do recover.

QUESTIONS SUBMITTED BY HON. STEVE DAINES

Question. Throughout the pandemic, assisted living providers in my home State have cared for over 6,000 vulnerable Montanans—many who are living with Alzheimer's or some form of dementia. Due to PPE needs, workforce needs, and occupancy declines, I continue to hear that many of these providers have suffered millions in losses throughout the pandemic and will struggle to sustain their operations without financial relief. There is roughly $23 billion remaining in the Provider Relief Fund to help support our healthcare heroes who are on the frontlines of the COVID response. I recently urged Secretary Becerra to distribute more of the remaining PRF to assisted living facilities and other senior care centers.

Do you support this request?

Answer. If confirmed, I commit to working with all of our Nation's front-line workers to ensure they receive the support and resources they need to care for those who rely on them.

Question. For decades, the Federal Government has funded telehealth research grants. These grants have been administered by more than 10 agencies and operating divisions across the Federal Government. Unfortunately, navigating the Federal grant process can be a challenge for the average provider and health system. Also, despite the Federal Government funding significant amounts of telehealth

projects, we have very little data to point back to and it seems that grant programs can be duplicative or at odds with prior projects. Additionally, we know that there is still a learning curve for providers, patients and caregivers on telehealth. As we continue the shift toward a health-care system that will include virtual care permanently, I believe there is value in ensuring there is a function within HHS today to help with issues of digital literacy and education.

Do you believe that we have a coordinated national telehealth strategy? Do you agree that a coordinated approach to telehealth investments and policies across at least HHS is important?

Would it be beneficial for there to be an elevated presence within HHS leadership to coordinate telehealth investments and policy across the Federal Government?

How can we improve digital health literacy for beneficiaries, caregivers and providers alike? Do you agree that this should be a focus for HHS as telehealth policies are adopted permanently?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe, while maintaining critical access to care. If confirmed, I will take a careful look at those telehealth flexibilities along with my colleagues at HRSA, SAMHSA, and CMS. I look forward to hearing more from you about what existing flexibilities you view as especially important.

Question. About 46 million Americans, nearly 15 percent of the U.S. population, live in rural areas like my home State of Montana. Those living in rural areas are more likely to die prematurely and face higher risks for chronic conditions like heart disease and diabetes. Americans living in rural communities face 17-percent higher prevalence of diabetes than those living in urban areas and may have to wait months before needing to travel great distances to see an endocrinologist to help manage their condition. This scenario is not uncommon and instead is the reality of rural Americans that routinely encounter not just a lack of specialty care but in many cases, primary care. Digital health tools, including telehealth and remote monitoring, have the potential to relieve some of the key healthcare challenges facing rural America.

Can you speak to the promise of telehealth and digital health care more broadly for rural communities?

Answer. I believe that we have to take every approach we can to provide Americans access to quality health care, especially in rural areas, and telehealth is an important tool to improve health equity and access to health care. Health care should be accessible, no matter where you live. If confirmed, I will look at how we can use telehealth to improve health equity and access to health care.

Question. Virtual care can help address existing health disparities by eliminating the barriers of time, distance, and geography, while empowering patients to overcome the challenges of accessing in-person care, something Montanans know too well. One of the lessons learned from the COVID–19 pandemic is the value of leveraging telehealth to scale and meet rising demand for key health-care services. Health workforce shortages were at critical levels before COVID–19.

I was pleased to lead the effort that resulted in section 3701 of the CARES Act, which created a temporary safe harbor that allows high-deductible health plans (HDHPs) to cover telehealth and remote care services prior to a patient reaching their deductible. This important safe harbor ensures that high-deductible health plans can support patients that are leveraging virtual care to access a range of critical health-care services during the pandemic before the annual deductible is met. The CARES provision extended the safe harbor only through December 31, 2021.

According to the Bureau of Labor Statistics (BLS), only 15 percent of workers employed in the private sector participated in an HDHP in 2010. By 2018, that number had risen to 45 percent. Today, the number is estimated to be 54 percent. Importantly, participation in HDHPs is even across wage groups and in industries with a significant proportion of black and Hispanic workers.

As the U.S. health-care system emerges from the pandemic, permanently extending the HDHP/HSA Telehealth Safe Harbor would allow half of American workers to continue accessing a range of clinically appropriate virtual services—for a range of common conditions—without the burden of first meeting a deductible. I look forward to working with my colleagues on this committee to support American workers and ensure this key policy continues beyond 2021.

Do you agree that there is value in expanding access to telehealth regardless of your health plan design?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe, while maintaining access to critical health care. If I have the honor of being confirmed, I would be happy to work with you on ways to continue to improve access to care, including through telehealth.

Question. One of the silver linings of this pandemic has been the widespread adoption of technology to bring people together, whether it be families scattered across the Nation or patients and their providers. Telehealth has truly taken root and we have seen exponential growth in telehealth adoption across Americans of all ages, locations and conditions. Much of the growth in usage among Medicare beneficiaries has been made possible by temporary flexibilities in place for the duration of the public health emergency. These include allowing Medicare beneficiaries to have telehealth visits from their home, regardless of where they live across the country. This has also allowed new types of providers, such as physical therapists and speech pathologists to practice via telehealth.

Do you agree that the expanded access to telehealth services has been an important component in protecting patients and providers during the Nation's response to COVID–19?

As Congress considers permanent telehealth reform, I hope you will be willing to work with us to ensure that telehealth is available to all of those that wish to use it. Do you believe that there are some telehealth regulatory restrictions that Congress and HHS can work together to address in the near term?

Answer. Telehealth has been invaluable during this pandemic to keep patients, their providers and their families safe, while maintaining access to critical health care. If I have the honor of being confirmed, I will be taking a careful look at telehealth along with my colleagues in the Centers for Medicare and Medicaid Services. I look forward to hearing more from you about what existing flexibilities you view as especially important.

Question. The coronavirus pandemic has underscored the value of vaccines for infectious diseases, including those that originate abroad. We all recognize that COVID–19 will not be the last time we have to respond to an outbreak for which vaccinations are necessary in order to stem an emerging public health threat.

Public policy should make vaccines as accessible as possible for our citizens. That is why current law requires that insurers provide coverage without cost sharing for all recommended vaccines, without limitation.

Yet, inexplicably, current HHS regulations implementing the law limit mandatory coverage to so-called "routine" vaccines on the Immunization Schedules. As a result, many vaccines for infectious diseases are not covered without cost-sharing, including those for current vaccines such as rabies, anthrax, Japanese encephalitis, yellow fever, and cholera, and those vaccines in the pipeline for malaria, chikungunya, dengue, and Zika.

Last year, my colleagues and I worked on bipartisan legislation included in the CARES Act that ensures immediate coverage of COVID–19 vaccines with no cost-sharing. As I said then, Montanans and Americans across the country need access to vaccines, and financial barriers should not stand in the way during a national emergency or otherwise.

Congress should not have had to be reactive. A forward-looking, uniform approach is needed to ensure that we are prepared to move quickly on vaccinations when the next pandemic occurs.

If confirmed, will you commit to quickly bringing agency regulations in line with the statute requiring no cost-sharing for all CDC recommended vaccines to maximize access to the best preventative measures against infectious diseases?

Answer. As we have seen over the past year, vaccines are a critical part of the public health system working to keep Americans safe. We need to be prepared for any potential future outbreak, and I agree we cannot afford to be reactive on this. If confirmed, I would be happy to work with you to ensure we are ready for the next public health emergency.

QUESTIONS SUBMITTED BY HON. TODD YOUNG

MENTAL HEALTH

Question. The coronavirus outbreak has created an unprecedented mental health challenge for our country. While we don't yet know the full impact of the coronavirus in this area, we do know it has forced Americans to isolate from their loved ones and other support systems—causing a troubling spike in mental health and substance abuse problems. A Kaiser Family Foundation poll found that 45 percent of adults say the outbreak has affected their mental health, while a different study estimated that the pandemic could cause as many as 150,000 additional "deaths of despair" from suicide and overdose.

In Indiana, preliminary data show that compared with 2019, last year had nearly a 50-percent increase in overdoses seen in emergency departments, with an 18-percent rise across the U.S. in just the first 4 months of the pandemic. In 2020, there was a 67-percent increase in the use of the opioid overdose reversal drug naloxone—further indicating a rise in overdoses.

As HHS Deputy Secretary, how would you try to address this growing mental health crisis—both in the immediate aftermath of the public health emergency and in the long term?

Given that mental health services cross many agencies, how will HHS coordinate efforts on this important issue? What programs or initiatives around mental health services would be your top priorities as Deputy Secretary?

Answer. Unfortunately, the COVID–19 pandemic has dramatically impacted mental health and well-being for too many Americans. If confirmed, I am committed to working on this issue, including strong coordination among HHS agencies to support programs and initiatives across the continuum of prevention, intervention, treatment, and recovery support services as well as strengthening enforcement of this country's mental health parity laws.

SOCIAL DETERMINANTS OF HEALTH

Question. Social determinants of health are the economic and social conditions in which people live, learn, work, and play—such as access to reliable transportation and stable housing. Addressing these factors can positively impact the health and well-being of the most vulnerable Americans.

Do you have specific plans to address the social determinants of health?

How would you work within HHS to better leverage existing programs and address the barriers to coordination between health and social services programs?

Answer. We need to be smarter about tackling our biggest health-care challenges and understanding the many factors that affect outcomes is critical. Good data is critical in creating good policy, which can save money and lives, especially for our most vulnerable. If I have the honor of being confirmed, coordination across HHS programs would be instrumental to addressing social determinants of health. I look forward to working together with you on this important issue.

QUESTIONS SUBMITTED BY HON. BEN SASSE

TELEHEALTH

Question. While my colleagues have pointed out many of the ways COVID–19 has challenged our health-care system and exposed existing inequities, one bright spot in the pandemic has been increased access to telehealth services as a way for patients to maintain their health from the safety of their homes. This has been particularly important for States like Nebraska with large areas of rural population.

We know that CMS has allowed expanded use of audio-only services during the pandemic, but how is CMS working to ensure that those without broadband access can utilize appropriate telehealth services in a post-pandemic world?

Where do you stand on audio-only telehealth coverage? What about on payment parity between in-person and virtual services?

How will you approach geographic restrictions, both in patient location and provider licensure?

If confirmed, how do you plan to evaluate the use of telehealth over the last year and the places where it should—and potentially should not—be expanded beyond the end of the national emergency period?

Answer. Telehealth is an important tool to improve health equity and access to health care. Health care should be accessible, no matter where you live. If confirmed, I would look forward to working with you and my colleagues at the Centers for Medicare and Medicaid Services on this issue.

Question. Individuals with chronic disease place an immense strain on our healthcare system and account for a huge percentage of the overall costs to taxpayers. I think you would agree that early identification and treatment is crucial not only among those with chronic diseases but in ourhealth systems in general. Remote patient monitoring (RPM) can be beneficial in managing both acute and chronic conditions and identifying deteriorations in health as early as possible to allow for the best level of care. Issues with reimbursement continue to constrain Medicare recipients' access to this level of monitoring.

Do you see value in increased access to remote patient monitoring and what are your views on the co-pay requirement for these services?

Answer. Individuals with chronic disease benefit from access to comprehensive and coordinated care to manage and treat their chronic conditions and prevent the need for more costly care. Ensuring access to remote patient monitoring services, including through evaluating the adequacy of payments, will be important to beneficiaries who may benefit from these and other virtual services that allow their physicians to help manage and treat their health conditions outside of regular office visits.

MOST-FAVORED NATION MODEL

Question. I have concerns with the Most-Favored Nation Model rulemaking, both with the policy of tying Medicare reimbursements to the prices foreign countries pay and with the creation of the expansive rule through the Center for Medicare and Medicaid Innovation (CMMI) under the guise of being a pilot program.

If confirmed, how will you approach this policy? Do you support tying the prices of American drugs to foreign prices?

Will you commit to ensuring that CMMI is used as intended rather than as a congressional workaround?

Answer. We can all agree that bringing down the cost of prescription drugs needs to be a top priority. If confirmed, I will work to coordinate efforts across the Department to make sure we make progress toward this goal, and I look forward to working with Congress on ideas that will result in lower costs for American patients and families.

COVERAGE OPTIONS

Question. As you have noted in the past, deductibles and premiums are often too high in the individual market for people who don't receive subsidies. This has been particularly true in Nebraska, where for years we had one provider on the market and where even today the cheapest plan available on the individual market has a premium of $1,700 per month for a family of four.

We have too often ignored the fact that States like Nebraska actually *lost* healthcare options as a result of the ACA. My State benefited tremendously from the previous administration's rules expanding Associations Health Plans and Short-Term Limited Duration Plans, and I'm concerned about the rules establishing these plans potentially being rescinded due to politics rather than actual data on their effectiveness or service coverage. These plans are very popular in my State and often cost less than half as much as ACA plans while providing more personalized coverage. Having fewer options in this case actually *increases* the number of uninsured.

In addition to your support for expanding subsidies in the individual market, would you also support continued access to more affordable options, such as Association Health Plans, Short-Term Limited Duration Plans, and Health Sharing Ministries?

If not, what data can you point to in recent years to say these plans haven't proven to be popular and affordable options while still protecting those with pre-existing conditions?

Can you point to any actual evidence that these plans destabilized the market?

Will you commit to working with Congress and other agencies to preserve these plan options for the millions of Americans who have enrolled?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. If confirmed, I will examine rules and other policies to ensure all Americans can access the care that they need.

Question. Another popular and successful product in my State are Medicare Cost Plans, which offer a unique product in supplemental Medicare. These plans are particularly popular in Western and rural Nebraska, where beneficiaries typically only have a fee-for-service product available to them.

Do you believe the rules prohibiting competition between Medicare Advantage and Medicare Cost Plans make sense in today's market, and does less competition benefit patients?

Answer. Medicare Advantage and Medicare Cost Plans have an important role in giving people access to care. If confirmed, I would be happy to work with you on the unique needs and coverage options available to Nebraskans.

Question. The previous administration worked on a rule to allow Direct Primary Care and Health Sharing Ministry expenses to be eligible expenses for use of health savings accounts under section 213 of the tax code. I believe strongly that Americans should be allowed to spend their health savings accounts on these services, and that more personalized choice in health markets leads to greater outcomes and higher quality care.

Would you commit to working with me to explore this policy change and others like it that expand access to these care and coverage options?

Answer. Making sure that all Americans have access to quality, affordable health care is one of the Biden administration's top priorities. As health-care costs have continued to rise, more burden has been shifted to consumers in the form of greater cost sharing. We must work to reduce barriers to access, including excessive cost sharing.

TITLE X, CONSCIENCE RULES

Question. The Department recently announced that it will replace the previous administration's Protect Life rule, which upheld the long-time separation between abortion and health services by calling for title X grant recipients to ensure that abortion services were not co-located with federally funded services. This policy has been affirmed previously by the Supreme Court, and I believe it protects the integrity of the title X program.

If confirmed, how do you plan to amend this rule moving forward?

While it will ultimately be a decision made by Congress, will you commit to supporting continued inclusion of the Hyde amendment in future appropriations packages, and if not, what is your justification for failing to protect the amendment, which has been the law of the land since 1976 and is supported by a majority of Americans?

Will you commit to not reimpose the contraception mandate on religious ministries like Little Sisters of the Poor?

Will you commit to ensuring that medical professionals are not forced to perform procedures, like abortion, that go against their religious convictions?

Answer. I understand that there are different, deeply held views on this issue. During my time in the Obama administration, I followed the law. If confirmed as Deputy Secretary, I will continue to follow the law.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. As a doctor, I strongly support increasing access to mental health services, especially in rural communities. Senator Stabenow and I have previously introduced legislation for many years that would allow mental health counselors and marriage and family therapists to receive reimbursement from Medicare.

Can you discuss how the Department of Health and Human Services can improve access for mental health services, especially for those on Medicare?

In particular, can you comment on the merits of allowing licensed professional counselors and marriage and family therapists to receive reimbursements directly from Medicare?

Answer. The COVID pandemic is taking a toll on Americans in so many ways, including their mental health. However, this Nation's mental health crisis did not begin and will not end with the pandemic. We have to address this challenge from every angle, including by bolstering our mental health workforce. Mental health counselors and marriage and family therapists have an important role to play in our health-care system. If confirmed, I will work with you and other members of Congress to better integrate mental health care into our health-care system.

Question. Rural communities are facing significant challenges, especially during the COVID–19 pandemic.

Can you please discuss your priorities for improving health in rural America?

Answer. I recognize that rural areas have unique needs and challenges. I've seen how rural areas can vary both among different States and also within a State. Rural areas in Wyoming can face different challenges than rural areas in Virginia or Georgia.

The COVID–19 pandemic has further exposed weaknesses in our health-care system for both providers and patients in rural parts of the country. Rural hospitals and pharmacies are often the backbones of their communities, providing both necessary health care and employment. We should look at ways to bolster the rural health workforce, better utilize telehealth, and make sure these communities have the support they need. If confirmed, I look forward to working with you to ensure that rural communities are not left behind during the pandemic and beyond.

Question. One of the most common challenges facing rural communities is recruiting enough health-care providers. These include doctors, but also nurse practitioners, physician assistants, nurses, and mental health providers, just to name a few.

What are your general feelings on Federal health-care workforce policy?

Answer. It is critically important to make sure we have enough providers to serve beneficiaries throughout the United States, including those in rural areas. This issue is becoming more acute as our population ages and doctors and other providers retire. If confirmed, I look forward to working with you and other members of Congress to find creative ways to bolster the health-care workforce.

Question. As you know, Medicare is the single largest funder of graduate medical education. Several years ago George Washington University released a study which found New York State received 20 percent of all Medicare's graduate medical education (GME) funding while 29 States, including places struggling with a severe shortage of physicians, got less than 1 percent.

Do you believe major reforms to Federal GME funding policy are needed?

Do you believe the current funding formulas exacerbate health-care disparities in underserved communities?

Answer. I believe it's important to make sure we have enough providers, particularly as our population ages and doctors and other providers retire. I want to thank you for your work to add 1,000 new Medicare graduate medical education slots at the end of last year—the first increase to the program in nearly 25 years. I understand that Congress has prioritized these GME slots for teaching hospitals in underserved communities and other shortage areas, including rural areas. Prioritizing these communities for GME slots may help with provider shortages as doctors tend to want to stay where they trained. If confirmed, I want to work with you to make sure we have a robust health-care workforce across the country.

Question. It is vital for the United States to learn from the COVID–19 pandemic and ensure we are better prepared for future public health emergencies. In particular, I am interested in addressing the supply chain for personal protective equipment (PPE).

How do you anticipate HHS partnering with the private sector supply chain to ensure that the country is ready for the next public health emergency?

Answer. The global pandemic has highlighted the vulnerabilities of the global supply chain for many products. In order to continue responding to the COVID–19 pandemic and better prepare the Federal Government to respond to any future public

health emergencies, it is critical that HHS work to improve and expand domestic supply chain capabilities. If confirmed, I'm committed to working on this urgent matter.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee meets this morning to discuss two key health-care nominations. Chiquita Brooks-LaSure is nominated to serve as Administrator for the Centers for Medicare and Medicaid Services, and Andrea Palm is nominated to serve as Deputy Secretary of the Department of Health and Human Services.

Ms. Brooks-LaSure has served at OMB, on staff at the Ways and Means Committee, at HHS, and in the private sector. She helped craft policies bringing down costs for seniors on Medicare. She helped to develop and pass key portions of the Affordable Care Act. At HHS she helped implement the law. She also worked hard to make sure that middle-class Americans shopping for private health insurance would get a fair shake thanks to strong consumer protections.

The Trump administration later undermined a lot of those protections, which has created a lot of new challenges for this committee and the Biden administration to address.

Ms. Brooks-LaSure is also well-versed in Medicaid policy. She's worked closely with everybody involved in Medicaid—the Federal Government, States, and private organizations—to try to expand coverage, improve care, and help people get ahead.

Continuing on the theme of impeccable qualifications and experience, Andrea Palm is a proven health-care agency leader who knows exactly what it takes to run HHS smoothly. She previously served as the Department's Chief of Staff and senior counselor to the Secretary during the Obama administration. More recently, she served as Secretary-designee of the Wisconsin Department of Health Services, a $12-billion agency with 6,100 employees. She's been the point person when it comes to the COVID response in the State of Wisconsin. She's also led efforts to expand insurance coverage, improve mental health care, and reduce hunger.

Bottom line, these are both highly qualified nominees who will be ready to go on Day 1 after they're confirmed by the Senate. There's a lot of work to be done at HHS in the months and years ahead, beginning with continuing the fight against COVID–19. Vaccinations are way up, but cases and deaths are still awfully high. There's a long way to go in this pandemic.

This committee's also going to keep up its work on other health challenges facing the American people. For example, I've said that every time we discuss our Federal health programs, we're going to talk about the transformation of Medicare. Medicare used to be an acute care program—broken ankles and bouts of the flu. These days it's a chronic care program—cancer, Alzheimer's, diabetes. This committee led the passage of the CHRONIC Care Act in 2017. The Trump administration slow-walked its implementation. I'm going to work with these nominees to turn that around.

Second, in the American Rescue Plan the Congress made a big down payment for mental health services based on the CAHOOTS program. It's all about using health care, rather than law enforcement, to help people experiencing a mental health crisis. It's been a big success in Oregon, and I want to expand it even further.

This committee is also putting a special focus on the issue of inequality in our Federal programs. Especially during the pandemic, the American people have seen the results of health-care disparities up close. Blacks, Latinos, and Native Americans have suffered and died from COVID–19 at much higher rates. However, it's not just about COVID–19. It's also about maternal health, because women today are more likely to die in childbirth than their mothers were a generation ago.

I also want to work closely with HHS on the issue of lowering prescription drug costs. That's because Americans get socked every time they walk up to the pharmacy window, and it's long past time for Congress to act.

Finally, this country needs a revolution when it comes to access to mental health care. The law says that mental health care and physical health care are equally important, but in practice, mental health is often given short shrift. This is a major priority for members of this committee, so we'll continue working closely with these nominees on this issue—and all these issues I've raised—when they're confirmed.

I want to thank Ms. Brooks-LaSure and Ms. Palm for their willingness to serve in these extraordinarily challenging and vital roles. I look forward to the discussion today.

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The National Association of ACOs (NAACOS) appreciates the opportunity to express our views on the nomination of Andrea Joan Palm to be Deputy Secretary of the Department of Health and Human Services (HHS) and Chiquita Brooks-LaSure to be Administrator of the Centers for Medicare and Medicaid Services (CMS). We strongly support the nominations of Ms. Palm and Ms. Brooks-LaSure and are hopeful that they and the Committee will consider the following issues in their work ahead.

NAACOS represents more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. Models include the Medicare Shared Savings Program (MSSP), the Next Generation Model, the Direct Contracting Model, and alternative payment models supported by a myriad of commercial health plans and Medicare Advantage. NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, outcomes, and healthcare cost efficiency.

NAACOS looks forward to working collaboratively with the Committee and today's nominees on these topics. Mostly notably, we hope these appointments will bolster the shift to value following recent years of policies that have hampered that critical transition. The transition to value should not be taken for granted. While much progress has been made in the past decade, this transformation is threatened. For example, according to new data[1] released by CMS, the number of participants in the largest and most successful value-based payment model, the MSSP, reached its lowest level since the Trump administration took office 4 years ago. As shown below, to start 2021, 477 ACOs are participating in the MSSP, down from a high of 561 in 2018 and the lowest since 480 participated in 2017, the Trump administration's first year in office.

In contrast to the diminishing number of ACOs, the MSSP continued to produce greater savings every year and saw its best year yet in 2019,[2] the most recent year for which data is available. Serving 11.2 million seniors in 2019, the MSSP saved

[1] *https://www.cms.gov/files/document/2021-shared-savings-program-fast-facts.pdf.*
[2] *https://www.naacos.com/press-release--py-2019-results.*

Medicare $2.6 billion and $1.2 billion after accounting for shared savings bonuses and collecting shared loss payments. Gross savings are shown below.

The Next Generation ACO Model, the premier accountable care model ran out of the CMS Innovation Center that emphasizes high risk and high reward, has also demonstrated great results. Serving 1.2 million patients in 2019, the model saved $559 million compared to the CMS-generated benchmarks and netted $204 million to the Medicare Trust Fund after accounting for shared savings, shared losses, and discounts paid to CMS. NAACOS urges CMS to extend the Next Gen model through 2022, giving time to install it as a permanent option for ACOs, either as a stand-alone track or option within MSSP. The model is scheduled to sunset at the end of 2021. The above results should speak for themselves and substantiate permanentizing.

Given the success of the ACO program and need to strongly support the transition to value-based care and payment, we request HHS re-examine the balance of risk and reward for ACOs to bolster ACO growth and therefore savings to Medicare and to support high quality, coordinated patient care. Among those changes, we request that HHS and CMS reverse certain policies from a 2018 MSSP overhaul, which CMS called the ACO "Pathways to Success." That overhaul included some damaging provisions such as a cut to the share of savings most ACOs are eligible to keep and a push for ACOs to assume risk too quickly. These policies have chilled ACO growth and should be changed.

NAACOS also recommends that HHS focus the value transition on providers, keeping them at the center of payment models instead of implementing programs and policies to attract new players into traditional Medicare. As a telling example of CMS's recent approach, in 2018 the agency released a model initially titled "Direct Provider Contracting," only to later drop the word "Provider." That name change went along with an emphasis on giving favorable treatment to entice new participants, such as payers, to the model at the expense of those who have been on the frontlines of the value transition for the past decade.

To support the ACO movement and recalibrate the value transition to center on and support healthcare providers, NAACOS recommends the following:

- Set a national goal to have a majority of traditional Medicare beneficiaries in an ACO by 2025.
- Deprioritize the rush to risk and build a population health infrastructure.
- Address overlap of competing payment models to prioritize total cost of care models.
- Strengthen incentives to attract new ACOs and retain existing ones.
- Provide meaningful funding to build infrastructure necessary to spur innovation and value through expanded advanced payments and grants.

To make progress on the broader goals listed above, NAACOS recommends enacting the following specific policy change this year:

- Adapt ACO and alternative payment model methodologies to account for COVID–19 anomalies.
- Halt implementation of the Geographic Option of the Direct Contracting Model and improve aspects of the Professional and Global Options to benefit legacy ACOs/providers.
- Improve the MSSP by increasing ACO shared savings rates, fixing key benchmarking and risk adjustment issues, allowing more time before requiring risk, and revisiting recently finalized quality policies.
- Make the Next Generation ACO Model permanent.
- Provide more timely and complete data to ACOs.

Ultimately, President Biden's administration inherits fewer ACOs than the Obama administration left at the start of 2017, which is a trend NAACOS hopes will be reversed under your leadership at HHS. We appreciate the work of the Committee on these topics and look forward to working with the nominees.

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April 15, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Patty Murray
Chair
U.S. Senate
Committee on Health, Education, Labor, and Pensions
Washington DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
U.S. Senate
Committee on Health, Education Labor, and Pensions
Washington, DC 20510

Dear Chairman Wyden, Ranking Member Crapo, Chair Murray, and Ranking Member Burr,

On behalf of the National Health Law Program, we write to urge you to support Chiquita Brooks-LaSure's confirmation as the next Administrator of the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). As a long-time thought leader and expert on access to health care for low-income people, particularly those most underserved by our health-care system, Brooks-LaSure has the expertise, experience, and dedication to advancing access to quality health care and health equity needed to guide CMS.

CMS provides vital health coverage to more than 100 million people through Medicaid, CHIP, Medicare, and the health insurance marketplaces. With over two decades of Medicaid and health-care reform leadership and expertise under her belt, as well as a demonstrated commitment to advancing health equity, Brooks-LaSure is an exceptional candidate to lead CMS.

Before her most recent work as a Managing Director at Manatt, Brooks-LaSure served in key leadership roles advancing implementation of the Patient Protection and Affordable Care Act (ACA) within the Obama Administration. She served as Director of Coverage Policy in the White Home Office of Health Care Reform, and later as Deputy Director for Policy at CMS' Center for Consumer Information and Insurance Oversight. Before that, she served as staff on the House Ways and Means Committee, where she contributed to the ACA's passage.

Throughout her career, Brooks-LaSure has emphasized Medicaid and the ACA marketplaces' crucial roles in alleviating racial inequities in health outcomes. She has called out the role of the Trump administration's Medicaid work requirements and 2019 public charge rule in perpetuating health inequities, particularly for people of color. She has highlighted the importance of more robust data collection to better serve underserved populations and alleviate health inequities. Brooks-LaSure has stressed the importance of centering community voices in health policy development

and priority-setting—an approach that is essential to fostering a healthier and more equitable country for all.

Brooks-LaSure has paid particular attention to our country's unconscionable Black maternal health crisis. She has underscored the importance of extending Medicaid and CHIP to 12 months postpartum—a reform now possible through the American Rescue Plan Act's new state plan amendment options. She has addressed the importance of efforts to expand access to doula care. Her testimony at a 2019 House Ways and Means Hearing on pathways to universal health coverage specifically highlighted racial injustices in maternal mortality.

The challenges facing this nation are multifold, both acute and long-simmering. The pandemic has exposed flagrant flaws in our health-care system and painfully revealed the United States' entrenched health inequities. There is much to be done and undone to build a more robust and equitable health-care system. Our country desperately needs a CMS administrator who will center urgent health equity challenges and prioritize equitable solutions. We look forward to working with Brooks LaSure and the team at CMS to advance those solutions. We urge the Senate to confirm her nomination swiftly and resolutely.

If you have any questions, please contact Madeline Morcelle at morcelle@healthlaw.org.

Sincerely,

Elizabeth Taylor
Executive Director

Mara Youdelman
Managing Attorney, Washington, DC Office

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