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THE PRESIDENT'S FISCAL YEAR 2022 HHS BUDGET

HEARING

BEFORE THE

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CONTENTS

OPENING STATEMENTS

ADMINISTRATION WITNESS

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATION

THE PRESIDENT'S FISCAL YEAR 2022 HHS BUDGET

THURSDAY, JUNE 10, 2021

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

The hearing was convened, pursuant to notice, at 10:07 a.m., via Webex, in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Warner, Cortez Masto, Warren, Crapo, Thune, Burr, Portman, Toomey, Scott, Cassidy, Lankford, Young, and Sasse.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Eva DuGoff, Senior Health Advisor; and Joshua Sheinkman, Staff Director. Republican staff: Kellie McConnell, Policy Director; Gregg Richard, Staff Director; and Connor Sheehey, Health Policy Advisor.

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

The CHAIRMAN. The committee will come to order. This morning the Finance Committee welcomes Secretary Becerra to discuss the President's 2022 budget proposal for the Department of Health and Human Services.

There is much to talk about. I am going to begin with out-of-control prescription drug prices. Far too many Americans are getting clobbered with every trip to pick up their medications at the pharmacy window. The latest drug pricing news is the approval of Aduhelm, a new medication for Alzheimer's disease, one of the chronic diseases that now defines Medicare in the modern day.

The drug's approval is controversial. There is little data showing it actually does what the company says it will do. Despite that, Aduhelm has an unconscionable list price of $56,000 per year. Let us understand. It is not a cure like some other recent breakthrough drugs have been. Patients could be on Aduhelm for years at a time after their diagnosis, multiplying the overall cost of treatment.

Setting aside the lack of clear evidence that this new Alzheimer's drug actually works, medical science today is clearly capable of miracles. The speedy development of highly effective coronavirus vaccines is just one example. Every single member of the Finance Committee welcomes and cheers those advances. However, Americans are terrified by the status quo on prescription drug pricing. Not only are too many Americans foregoing or rationing their pre-

scriptions, sky-high drug prices could bust Americans' health-care budgets.

I am working now to update the Finance Committee's prescription drug legislation from the last Congress, and I welcome the ideas of all members of the committee. I believe that it is long past time to give Medicare the authority to negotiate better prices for prescription drugs on behalf of more than 50 million seniors. Overwhelmingly, the American people support this idea.

President Biden, during his speech in April to the Joint Session, called on Congress to get it done. We are all hungry for genuine medical breakthroughs, but, Senators, I would simply say, what does it mean if the vast majority of Americans cannot afford them?

A few other issues relating to the budget proposal and the administration's priorities at the Department of Health and Human Services. It is very welcome to see proposals on mental health, because mental health care is a major priority for the committee. We will have a lot more to say on mental health during our Finance Committee hearings on that issue next week.

As I discussed with Secretary Becerra, I look forward to continuing to work with his team on further implementation of the CHRONIC Care Act, specifically expanding its benefits to those who receive traditional Medicare. That way, the law that we passed in 2018 will continually be able to update the guarantee that is Medicare. I am also pleased that the administration is continuing to make progress on the issue of transparency and sunlight with respect to health-care prices. It is important to make sure that progress is useful to consumers as part of an overall effort to make health care more affordable.

The budget also includes a landmark investment of $400 billion to expand access to home and community-based services through Medicaid. This will be an absolute game-changer resulting in more choices and better care for millions of seniors and those with disabilities. Senator Casey and I, along with a number of members of this committee, are working long hours to get this done. We are also interested in building up the care workforce to make sure those changes deliver on their enormous potential.

Finally, I will close on the subject of child welfare. A few years ago, this committee, on a bipartisan basis, put together the Family First law. It was designed to help more families stay together safely, instead of relying on foster care. One of the key goals of the Finance Committee—and there are a number of Senators here who were involved in this—was to get more help to black and Native American families whose kids are disproportionately represented in the child welfare system.

Unfortunately, the Trump administration gave short shrift to the implementation of this law, and it is not living up yet to its promise for a lot of those vulnerable youngsters. The Biden administration has an opportunity to change that. It is also proposing a new grant program that ought to help address racial disparities in the foster care system.

So, we look forward very much to working with Secretary Becerra. And there are a lot of kids and families who can benefit tremendously from the Family First law.

With that, I will turn it over to our friend, Senator Crapo, for his remarks, and then we will hear from the Secretary.

[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. And welcome, Secretary Becerra.

The events of the past year have emphasized the importance of the Department of Health and Human Services. Last year, the efforts of HHS and its subagencies ensured safe access to crucial health-care services, even at the height of the pandemic, through telehealth expansion and other emergency flexibilities. HHS also proved itself pivotal in partnering with private-sector innovators to help bring several safe and effective COVID–19 vaccines to the public in record time.

In the months ahead, the administration should work with Congress to build on these successes, as well as to address some of the challenges the past year has created or exacerbated. Certain aspects of the President's budget request seem aligned with these aims. The proposal describes the concerted effort to build on our program integrity efforts to tackle waste, fraud, and abuse, which harm taxpayers, patients, and families. Program integrity represents a clear area of common ground.

The budget request also highlights the importance of value-based care, which will prove indispensable as we work to lower health care costs while increasing health care.

Unfortunately, other aspects of the President's proposal raise serious questions and concerns. Medicare trust fund solvency remains a pressing crisis, jeopardizing benefits for tens of millions of seniors. And yet, this budget request proposes no meaningful policies to contain unsustainable spending growth.

In fact, apart from outlining trillions of dollars in tax increases and spending hikes, the budget proposal offers few policy details at all. Much of the blueprint focuses on vague references to agenda items with no meaningful discussion of how to pay for them. These policies stray substantially from the promise of unity and bipartisanship initially advertised by this administration.

Proposals to lower the Medicare eligibility age, for example, would likely crowd out private coverage without moving the needle on access or affordability, all on the American taxpayer's dime. The budget request also suggests using Medicare dollars to expand Obamacare, just as we saw with the original passage of the ACA more than a decade ago.

Rather than champion the market-based reforms that have made Medicare Advantage and Part D such resounding success stories for our Nation's seniors, the budget proposes a convoluted price control scheme for prescription drugs that would reduce access to life-saving cures in the years ahead.

For the roughly four in 10 seniors enrolled in Medicare Advantage plans, the policies referenced in the budget request could also mean drastic cuts which could jeopardize supplemental benefits like dental and vision.

The document also affirms prioritization of $400 billion to increase access to home and community-based services. Home and community-based services are a key lifeline for scores of Americans, and Congress should consider bipartisan policies to expand availability. This should include ensuring that States have the workforce necessary to meet demand. Unfortunately, media reports suggest that this $400 billion may be used to establish certain labor reforms that fail to address the gaps in patient services that States have experienced for decades.

That being said, I am confident that we can find areas of common ground, and I look forward to working with you, Mr. Becerra and Mr. Chairman, to advance consensus-driven policies on a range of health-care issues from telehealth to value-based care.

Mr. Secretary, it is good to see you again, and I look forward to your testimony and discussing these and other vitally important issues with you today.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, Senator Crapo.

Mr. Secretary, we look forward to your remarks.

STATEMENT OF HON. XAVIER BECERRA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary BECERRA. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you.

The Department of Health and Human Services is at the center of many challenges facing our country today. The COVID–19 pandemic has shed light on how health inequities and inefficient Federal funding can leave communities vulnerable to crisis. Now, more than ever, we must ensure that the Department has the resources to achieve its mission and to build a strong public health system and a healthier America.

For HHS, the budget proposes $131 billion in discretionary budget authority and $1.5 trillion in mandatory funding. This budget underscores the administration's commitment to prepare the Nation for the next public health crisis, to expand access to affordable health care, to address health disparities, to tackle the opioid and other drug crises, and to invest in other priority areas like maternal health, tribal health, and early childhood education.

Now, we know the fight against COVID is not yet over, but even as HHS works to beat this pandemic, we must also prepare for the next public health challenge. To start, the budget makes significant investments in our preparedness and response capabilities, including by investing in the Strategic National Stockpile and the public health workforce.

It provides a new mandatory funding stream for the manufacture of medical countermeasures here at home to protect Americans from future pandemics, and to create U.S. jobs. The budget includes the largest fiscal year investment in the CDC in almost 2 decades.

The budget reflects the President's commitment to expanding access to quality, affordable health care for all Americans. It builds on the groundbreaking reforms introduced in the American Rescue

Plan by permanently extending the enhanced premium subsidies that put affordable health-care coverage within reach for millions of Americans. The budget also expands access to home and community-based services under Medicaid, critical services that allow older Americans and our loved ones with disabilities to live independently in their homes and communities. And the budget calls on Congress to take additional steps this year to lower the cost of prescription drugs and further expand and improve health coverage through additional benefits and public coverage options.

Health care must be a right, not a privilege, and we will work hard to ensure that families across the Nation are able to secure the health care they need. As we work to expand access to affordable health care and address the challenges of COVID–19 and future pandemics, we need to address public health crises that are already here, like violence in our communities and climate change.

The President's budget increases funding to support domestic violence survivors. It addresses gun violence by doubling funding for firearm violence prevention research, and it allows HHS to play a major role in the administration's government-wide efforts to tackle the climate crisis by supporting research and programs identifying the human health impacts of climate change, and establishing an office of climate change and health equity.

To ensure that HHS is equitably serving all Americans, the budget invests in reducing maternal mortality and morbidity, which disproportionately impact women of color. It builds on the American Rescue Plan's State option to extend Medicaid postpartum coverage. It funds a range of rural health-care programs and expands the pipeline for rural health providers. It includes a dramatic funding increase and advance appropriations for the Indian Health Service. And it invests in improving access to vital reproductive and preventative care services through title X.

To support families and build the best possible future for our children, the budget makes major investments to ensure high-quality child care is affordable to low- and middle-income families, and to provide high-quality pre-K for all 3- and 4-year-olds. We know our experiences as children shape who we are as adults. Support for children in their childhood leads to success in the future for all of us.

To address COVID–19's unprecedented acceleration of substance abuse and mental health disorders, the budget provides historic investments in SAMHSA to support research, prevention, treatment, and recovery services. To support innovation and research, the budget increases funding for NIH by $9 billion, $6.5 billion of which will go to establish the Advanced Research Project's Agency for Health, ARPAH, with an initial focus on cancer and other diseases such as diabetes and Alzheimer's. This major investment in Federal research and development will leverage ambitious ideas to build transformational innovation to help research and the application and implementation of health breakthroughs.

Finally, to ensure our funds are used appropriately, the budget invests in program integrity, including efforts to combat fraud, waste, and abuse in Medicare, Medicaid, and private insurance.

Mr. Chairman, I would like to close by recognizing the women and men at HHS for their outstanding and tireless work fighting

COVID–19 to protect the health of their fellow Americans. To build back a prosperous America, we need a healthy America. We have taken important steps over the past few months to beat back this pandemic, to expand access to quality, affordable health care, to lower health premiums, and to protect women's health at home and abroad.

President Biden's budget builds on that progress. Thank you.

[The prepared statement of Secretary Becerra appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. Secretary. We will just go to 5-minute rounds on questions of members.

Now if only a fraction of seniors suffering from Alzheimer's were prescribed Aduhelm, Medicare Part B spending would double overnight. Seniors taking the drug would be asked to pay more than $11,000 in co-insurance each year.

Now the President has called on the Congress to lower the cost of prescription drugs through negotiations. And you, to your credit—I just learned this at the Ways and Means Committee—you basically said, "Just give me the authority. I want the authority. I want to go to work."

Tell us, if you would, what kind of tools would be most useful to you in using that authority? For example, one that comes to my mind would be finding a way to get analysis of prescription drugs to determine which ones were the best, and you could factor that into your decision-making.

But I would be curious, because people say, "All right, we hear from Senators Medicare should negotiate." Tell us a little bit about what kind of tools you would use, if you got the authority you were talking about yesterday at the Ways and Means Committee.

Secretary BECERRA. Mr. Chairman, I can go on forever, but I will keep it brief. I will tell you that one of the things that is always helpful is oversight. The more we can have eyes on what is going on to make sure the industry is doing the right thing, that providers are handling these medications and medical supplies properly, the more we know that we are getting good bang for the buck for the American people. But there are other ideas.

You have had ideas in your legislation that I know you are trying again to move forward with. Maybe the negotiation of drug prices. You can talk about providing drug rebates in the event that a manufacturer tries to increase the price of a prescription drug by more than inflation. There are any number of good ideas that are out there.

As I said, give us the authority and we will go to work.

The CHAIRMAN. Very good. And you are going to get questions from my colleagues about that as well.

I would like to talk to you about the CAHOOTS law. We, as you know, were able to procure a billion dollars in Medicaid funding for the States for an approach that I believe is a pioneering strategy with respect to mental health.

We know that we have enormous challenges as it relates to a lot of what goes on on the streets of this country, and the CAHOOTS law has brought together mental health officials and law enforcement officials in an unparalleled kind of way. What happens is, when a 911 call comes in, a similar call is made to the mental

health people, and law enforcement people coordinate what is the right kind of approach.

Now we are in the administrative stage, and I would be interested in how the Department is preparing to work with the States so these dollars can really get out there quickly for something that I know in Eugene, OR—which has the original CAHOOTS program, gave me the idea for it—is making a difference. Your thoughts?

Secretary BECERRA. Mr. Chairman, we want to get that out there as quickly as possible. If I could just mention that, as the Attorney General for California these last several years, one of the things that we were trying to do is work closer with all of our local law enforcement agencies, with our county health offices and mental health offices, so we could do exactly what you are trying to do through CAHOOTS.

And so we are getting ready to issue some guidance. We are hoping to move quickly, fairly quickly, to issue those regulations so we can get this on the ground and let that mobility that you provide in CAHOOTS help us address the mental health needs of so many Americans.

The CHAIRMAN. Let me ask you one other question. Especially a couple of my colleagues are up here on the dais who joined me some years ago in an effort to modernize employer-based health coverage, which we all know came from the 1940s when there were wage and price controls and just put it on the employer.

So these two gutsy colleagues, years ago—and I think they will remember this—joined me in an effort to try to modernize the system. We wanted to say that for those who wanted employer-based coverage, great. But we ought to have more options.

Now the American Rescue Plan made health insurance through the exchanges more affordable. For many families, there are no premiums. No matter what you make in a year, you are not paying more than 8.5 percent of your income. But if your employer offers you health insurance, different rules apply. Only when the premiums for your employer's plan are 10 percent of your income can you go to the exchanges to get affordable health insurance. This is what is known as the "health insurance firewall." The practical effect is families paying thousands more per year for their health insurance, when more affordable options exist just out of reach.

So my question, Mr. Secretary—and I am not sure you have been asked about this in public, but we have talked about it—is, do you agree that the definition of "affordability" should be the same in the exchange and for employer coverage?

Secretary BECERRA. You are right: I have not been asked that question. And what I would tell you is that I think most Americans would tell you they only have one definition of affordability. Can they pull money out of their pocket and afford the health care they need for their kids?

And so what I would tell you is, we have to work together to make sure that we end up with a uniform response that says affordability, regardless of how you define it in the statute in one code section or another, has to mean it is affordable for the American people.

And so I would tell you that we will work with you to make sure that, at the end of the day, the definition is the one the American people want to see.

The CHAIRMAN. Well, I think that is a very constructive response. I think health insurance should not cost anyone more than 8.5 percent of income, which is, in effect, what the concept would be all about. And I look forward to working with you on it.

Senator Crapo?

Senator CRAPO. Thank you, Mr. Chairman.

Mr. Secretary, during your nomination hearing process, you expressed support for State-led innovation advanced through waivers. The two waivers receiving the majority of this committee's attention are the 1115 and 1332 waivers, which empower the States to better target their Medicaid and individual marketplace populations.

Since your confirmation, the administration has taken the unprecedented step of rescinding an 1115 waiver previously granted to Texas. And as you know, there has been quite a bit of furor over that. And that would have allowed the State of Texas to expand its services for mental health coverage, in addition to other things.

Like many of my colleagues on this committee, I believe that this type of action raises profound concerns. I understand that there is now attention to looking at the 1332 waiver that Georgia recently received, and that the administration is apparently moving into a pattern of reviewing existing waivers to withdraw them.

First of all, is the administration currently considering rescinding additional waivers? And do you believe that, if that is the case, there should be a very open, transparent process where the public is not only involved but aware of the administration's efforts in these areas?

Secretary BECERRA. Senator, thank you for the question. I know this is an important one for the members, and it is also an important one for us because these waivers are, as you said, crucial. We want to make sure the goals of the Medicaid program are fulfilled. We want to make sure that we get more people into health coverage.

And when we review these waivers—again, waiving existing law so that States can try to do it more innovatively and hopefully save money and get more people coverage and care—we want to make sure that is the ultimate goal. And so, when we look at some of these waivers, or we put any on hold, it is because we want to make sure that the goals of getting more people covered at a better price are being achieved.

And we are currently in discussions with the State of Texas—also with the State of Georgia—and we are working closely with the State of Texas. They are in the process of resubmitting a waiver request. They have a waiver that exists today that still runs until probably about mid-next year. And so we are going to make sure that we are working with States who want to innovate to make sure that, if they need a waiver or have a waiver, that we can continue forward.

Senator CRAPO. Does the administration intend to outline its authority for these reviews and provide the opportunity for public

comment and involvement and awareness of what the rationale of the agency's actions are?

Secretary BECERRA. A great question. I think when we had our discussion, I mentioned to you that we are looking at transparency and accountability first and foremost. So if there is a notice and comment period so that everyone—stakeholders, the consumers—have a chance to make a comment about a proposed waiver, we want everyone to be able to weigh in so when we make a decision on granting a waiver, it is based on all of the information necessary.

Accountability—we want to make sure that, at the end of the day, when you are talking billions, or in many cases tens of billions of dollars, that it is used properly. Because these are taxpayers who are helping these States move forward with their innovative projects.

Senator CRAPO. Well, thank you.

I would like to move to the Medicare trust fund. The Social Security Act, as you know, established the Medicare board of trustees to oversee the financial operations of the trust fund. And you are a member of that board. The Medicare trustees' report is 71 days late. As a member of the board, do you know what the revised exhaustion date is of the hospital insurance trust fund?

Secretary BECERRA. Senator, I know that there have been revisions in the past on the date. We are now being told that it is imminent in the next several years. We will find out soon if there have been any adjustments. But the most important thing here is that we have to work together to continue Medicare moving forward for the tens of millions of seniors who depend on it.

Senator CRAPO. Do you have any information about when the trustees' reports will be released?

Secretary BECERRA. Let me get back to you on that, because I have not been given any particular date.

Senator CRAPO. All right; thank you. And if the upcoming 2021 Medicare trustees report does show—and I hope it comes out soon—that the trust fund will be depleted earlier than 2026, do you know whether you and the President will immediately propose a detailed plan, including policy specifications and corresponding cost estimates that extend the life of the trust fund?

Secretary BECERRA. I know the President has had many ideas during his long tenure in service on these issues, and that at HHS we have been working on some of these as well. We will be more than happy to work with you and your colleagues to try to come up with a plan.

Obviously, anything we propose will require, for the most part, congressional approval. So, we will look forward to working with you to make sure that we keep Medicare strong.

Senator CRAPO. Well, I encourage you to do so, because I expect we will face that situation.

Let me, in my last question here, say quickly, the President's health-care and human services budget before us does not include policy specifications or cost estimates regarding a number of the health-care proposals, such as lowering the Medicare age of eligibility to 60. Mr. Secretary, when will we see a policy outline and scoring estimates for these administration requests?

Secretary BECERRA. And, Senator, there I think the President has signaled very strongly. We need to continue to try to extract as much value out of every dollar for health care. And certainly as the chairman has said with regard to prescription drugs, I think everyone agrees that the prices are way too high.

And so, there are any number of ideas. Rather than outline a specific approach, we have indicated, for example, negotiating Medicare drug prices would save us several hundred billions of dollars. We could do something similar to what Senator Wyden and Senator Grassley had proposed where you push on rebates so that, if a drug company tries to increase prices too quickly, you get a rebate back from them. That saves tens of billions of dollars.

The numbers are out there, whether from CBO or OMB. We are willing to sit down and come up with a solution. We know that you need to get the votes to pass something, but we are game and ready to go.

Senator CRAPO. All right; thank you.

The CHAIRMAN. I thank my colleague.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman, and welcome, Mr. Secretary. It is wonderful to see you. I appreciate all the work that you are doing and that the Department is doing on really, really important things that affect people in Michigan, and people across the country, every single day.

It will be no surprise that I want to talk to you about health care above the neck, as well as health care below the neck. Because when we look at the fact that, during the pandemic, mental health and substance abuse issues have increased substantially—and they are going to linger long after everything is done here. And we appreciate all the outstanding work you have done on the pandemic, and on vaccinations, to bring us out of this crisis.

But the good news is, as you know, that we are making significant progress with high-quality, comprehensive mental health and addiction treatment in the community around the country with the expansion of Certified Community Behavioral Health Clinics. And the fact that this is funded through the health-care system, not just grants—I appreciate that startup grants are in the budget, that is great, but it is not enough. We need to fund health care above the neck the same as health care below the neck.

So, we now have these services in 40 States, and in DC. And they do include 24-hour psychiatric crisis services, working with law enforcement, and programs like the chairman has championed with CAHOOTS. So could you talk about the—because I know in your budget, you lay out the positive impacts these clinics are having around the country.

Secretary BECERRA. Senator, I am preaching to the choir. In fact, you are the conductor on some of these things, and so, thank you very much for the work that you have done over the years.

We are not going to stop, because, as you have said, we have not fulfilled our commitment to make sure we treat mental health with parity to other physical health conditions. And so, you did us a great favor with the American Rescue Plan. You provided us with some resources. About 3 weeks ago we announced the launch of an initiative of $3 billion to help, half of it going to mental health

services, half of it going to substance use disorder services. That would not have been possible without your help.

We continue to work with you. This budget increases the funding and the efforts to try to tackle this. But you are absolutely right: we are behind on this, and we hope to catch up as much as you will let us.

Senator STABENOW. Well, thank you. And as you know, there are concrete results. I mean, we are seeing 60 percent fewer people going to jail, just because there was no place else for them to go and they needed services; 63 percent fewer people sitting in emergency rooms waiting for help that is not there; 41 percent fewer people in homeless shelters. And so, some real differences—concrete, measurable differences.

And I think that is why we have such strong bipartisan support. So I would just urge you on, as Senator Blunt and I are introducing the next step, which is really to allow States across the country to be able to put these clinics in place.

Chairman Wyden is working closely with us. We have Republicans and Democrats on this committee working with us, and I hope that you will work with us to get this done. Can we count on you to do that?

Secretary BECERRA. You had me at "hello" on that one.

Senator STABENOW. Thank you. Let me also just ask, as I am looking here at—I think I have gone over my time here, but I am going to ask one other thing. That is, when we look at the new Alzheimer's drug cost, and I have been very involved in bipartisan efforts over the years. We have put a lot more into research. But if people cannot afford the products ultimately that come out of the research, we have not done our job.

And so, I was appalled that Biogen priced their Alzheimer's drug that was approved by the FDA at $56,000 per year. I am not going to debate whether this is effective or not, but I can just say this is more than double the median household income for Michiganders over 65. It is double the Social Security yearly income, more than the average income, and I am extremely concerned about where this is going in terms of cost to seniors.

So, as somebody who authored the amendment to provide you the authority to negotiate under Medicare, I hope that you will continue to look for every possible way in order for us to bring prices down. $56,000 a year is impossible for people.

Secretary BECERRA. Senator, innovation is effective only if patients can afford it. And so I look forward to working with you so we have that ability.

Senator STABENOW. Thank you.

The CHAIRMAN. I thank my colleague. Senator Cassidy is next. And, colleagues, there are a number of people who signed up to be on the web and we cannot reach them, so we are just going to constantly be trying to get people in order of their appearance. And Senator Cassidy is here, and we cannot get the folks on the web.

Senator Cassidy?

Senator CASSIDY. Mr. Secretary, how are you?

Secretary BECERRA. Very well.

Senator CASSIDY. Mr. Secretary, it is my understanding that HHS is still working at 25-percent capacity, limited capacity. Now,

I keep on thinking of the folks back home paying our salaries, and they are going to wonder, if CDC has said that we can go back to work, why isn't HHS back to work?

And I looked at the workplace safety plan for HHS, and it says 25 percent of normal capacity during periods of significant or high community transmission, but DC, Loudoun County, and Prince George's are all at 1 percent of testing positive, which is moderate at most.

How come you are still at 25-percent capacity and my folks back home are paying for the salaries for folks who are not in place?

Secretary BECERRA. Senator, probably the best way to respond to that is to say that in the time that we have been in charge or in office, we have seen the number of COVID infections dramatically drop. The number of people vaccinated has dramatically increased. We are doing our job. That not everybody is back, coming into the office, is not a signal that we are not at 100-percent capacity in terms of the work product.

We continue to produce and——

Senator CASSIDY. I expect that, but still there is kind of a general expectation that people show up to work. And granted, some would be able to work from home, but I have also learned that some cannot work from home. There have been people 14 months at home who could not work because their work could not be gone over online.

So, I understand there is at least a portion of those employees. And knowing that the CDC has given their updated recommendations, when might we expect that new recommendation to come in?

Secretary BECERRA. Senator, I think you are seeing that we are doing the work, as you see from this committee hearing room that there are only a certain number of Senators here as well during this hearing. Everyone is doing their work. We may not be doing it as we physically saw it done a year and a half ago, but——

Senator CASSIDY. That might be, but is that to say that you never intend to come back to full work capacity?

Secretary BECERRA. Oh, of course we are going to go back to giving people an opportunity to come back physically. But the transition will take a little time. There are families who have kids, who have to take care of their children. There are people who, for whatever reason, cannot be vaccinated, who have to be very careful.

The issue of public transportation, as you know—here in Washington, DC especially, a lot of folks take public transportation. So, as we transition back to a more normal way of doing business, I think what you are going to find is that people will appreciate the chance to come back safely. But we are doing more than 100-percent capacity of work in the performance that is required of HHS.

Senator CASSIDY. Although, if you are like other agencies, there are people who have not done anything for 14 months, just because the nature of their work could not go home with them because it was too secure. I have learned that, with Social Security, there is a whole group of people, the union workers, who are not able to take their work home, and so they literally have done nothing in terms of work.

So anyway, just to move on. Looking at your budget, the trust fund is going—I am not talking about B or D, but the trust fund is going bankrupt in 2040. And I see that you have some plans to at least shore it up. But one of my concerns is that a significant portion of the revenue is basically double-counted. It is being used not only to strengthen the trust fund, but also to finance the American Family Act.

These are some of the tax provisions that are changed. And according to one projection I have read, the net effect of what is happening will only strengthen—if we do not include transfers from the general fund but only the new revenue coming in from other sources—the net effect only extends the lifespan of the trust fund to 2029. Now that is you and me, man [laughing], you know.

So, what comments do you have on that? And are we going to begin to count increasingly upon transfers from the general fund in order to strengthen the Part A program?

Secretary BECERRA. Senator, I think I can say this with confidence that you and I, and pretty much every member in Congress and in this administration, will do everything necessary to keep Medicare strong. It has worked too well. Tens of millions of Americans depend on it. They paid for it. I will note, it can never go bankrupt because of the way the law is written. It can never spend more than it gets.

And so, the concept of bankruptcy does not apply to Social Security and Medicare.

Senator CASSIDY. It doesn't, but by that same law it means that payments to providers will decrease to the proportion that is coming in. And if you speak to a physician and you say to her, listen, you are only going to get paid 80 percent of what you currently receive from Medicare, she would say, "I will not see a Medicare patient. I cannot afford it." You cannot make up by volume when you lose on every case.

So, what are the kind of, if you will, what are the significant plans, for example, to decrease expenditures within the Medicare program?

Secretary BECERRA. And to the point, that is why we will not let this occur. Because I do not think any one of us wants to expect a physician or other health-care provider to do the services expected for far less than would be reasonable.

And the number of solutions that are out there, that have been out there for years—I remember when I was in Congress, many people had proposed a number that involve things like what we did with the Affordable Care Act, which added years to the life and solvency of the Medicare system.

It could be reducing the cost of prescription drug medication——

Senator CASSIDY. But I am speaking specifically about Part A, not B or D. Just the hospital trust fund.

Secretary BECERRA. There are still efficiencies that we can extract in the way we reimburse hospitals when it comes to the current system of fee-for-service, and also Medicare Advantage. We will be working with you on any number of those solutions. But at the end of the day, when Congress decides it wants to come up with the big solution, we will be there working with you to make sure we can implement it.

Senator CASSIDY. Thank you. I yield back.

The CHAIRMAN. I thank my colleague.

Senator Thune is next.

Senator THUNE. Thank you, Mr. Chairman.

Secretary Becerra, you and I had a conversation during your confirmation hearing about the issue of abortion, and you testified that you understood that there are differing views on the issue, and expressed hope for finding common ground.

Recent polling suggests that 60 percent of Americans oppose using tax dollars to pay for abortions, which the Hyde Amendment prevents. And that seems to me like an area of common ground. Yet, in your and the President's budget, you propose to eliminate the Hyde Amendment.

And so I guess my question is, if maintaining Hyde is not your idea of common ground, what is?

Secretary BECERRA. Senator, at the end of the day we have to try to make sure that we are providing the best health-care services to all Americans as possible. I think the law of the land does say that women, just like a man, are entitled to have the health-care services that they need. And so we would try to move forward to make sure that we provide access to good quality care as affordably as possible. And we are going to move forward to try and fulfill that area of the law. And we do know there is great support for *Roe v. Wade* and trying to protect the woman's right to decide how to treat her own body and her health-care services. And so, I hope that what we will do is achieve common ground on how we can get that done.

Senator THUNE. And I would just say in response to that, the Hyde Amendment goes back to the 1980s, and it always has been understood, even by the President of the United States when he was a member of the U.S. Senate, that that is an area of—you know, having tax dollars, American tax dollars used to support that is a bridge too far, and something that both sides have agreed through the years, in legislation, not to cross.

And it is very, I think, disappointing for one, but two, inconsistent with what has been long-held bipartisan policy on that issue, to try and do away with Hyde. And so, I cannot disagree more with you, or with the administration on their view on that. It has consistently been—on a very controversial issue, granted—the area where there has been broad bipartisan agreement through the years.

On the issue of telehealth, I notice that the budget does not contain Medicare-related legislative proposals to address the telehealth flexibilities that have been available throughout the pandemic. What has the Department been working on to ensure that progress is not lost? And have you identified any specific telehealth policies that you want to see Congress work on?

Secretary BECERRA. Great question, Senator. It is something that is important to so many Americans. We look forward—having taken the lessons of COVID–19 and how telehealth became so important to so many communities—to then put that into practice moving forward. We will need some authorities to have flexibility to do some of these things within Medicare. And we hope that Con-

gress will help us move forward in ways that really do harness the types of things that we learned from COVID–19.

We want to make sure that broadband is accessible in all communities. We do not want to leave anyone behind as we move toward more telehealth. And we are learning that you can do a lot of good health care without ever having to even see the person that you are providing treatment to.

So there are any number of lessons that we have learned from COVID, and we hope that Congress gives us some broader authority and some resources to make it happen.

Senator THUNE. Thank you.

As you know, many of us on this committee are interested in how HHS and Treasury are verifying eligibility for the newly expanded ACA subsidies. And I think we would welcome any commentary that you can share now in response to the letter that we sent last month.

Additionally, in light of the budget's proposal to make these expanded subsidies permanent, what analysis has been done by the Department to understand the effect of the proposal on premiums and enrollment in the large and small group markets where most Americans get their coverage?

Secretary BECERRA. Senator, we will look forward to working with you and sharing that data. What we are trying to do is avoid, obviously, those families, mostly middle-class families, who all of a sudden hit this cliff when it comes to coverage, and fall off the cliff simply because they may have gotten a small raise in their work and now, all of a sudden, that health care that they were able to afford now becomes unaffordable, eats up all that modest raise they may have received.

We do not want folks falling off that cliff. And so we will share that data with you as we work towards a solution.

Senator THUNE. For years we have heard about adverse selection, the risk it poses to insurance markets for individuals to wait to purchase health coverage until they need it. The budget highlights the special enrollment period for the ACA exchanges that will have been ongoing for half of 2021 by the time it ends in August. What analysis has the Department done on how this affects the risk pool? And can we expect to see the administration continue to pursue such a drastically extended enrollment period moving forward?

Secretary BECERRA. We will share data on that as well. But I am pretty sure that most of the insurers will tell you—the fact that more than a million people have taken up the call to sign up for health care means today we have more than 31 million Americans receiving their health care as a result of the Affordable Care Act.

That helps insurers because, as you know, you have to spread your risk as an insurance company. Well, the more people who come into the system, the less risk you have that one of those people will be very sick. And so at the end of the day, I think this is going to be not just good for the providers and the insurers, but certainly for the Americans who are getting health care.

Senator THUNE. My time has expired.

The CHAIRMAN. I thank my colleague. Our next three, in order of appearance, are Senator Carper, who I believe is on the web;

Senator Toomey, who is on the web—and we need Senator Toomey to turn his camera on; and then Senator Cardin, who is now here. So we will begin with Senator Carper.

Senator CARPER. Thanks, Mr. Chairman [faintly].

The CHAIRMAN. Senator Carper? There you are. Let's see if we can hear you.

Senator CARPER. Mr. Secretary—— [faintly].

The CHAIRMAN. Tom, it is the same problem that you had yesterday, my friend.

Senator CARPER. Okay. All right. Can you hear me now?

The CHAIRMAN. There you are. Now we can hear you.

Senator CARPER. [Garbled speech.]

The CHAIRMAN. Now we cannot make anything out.

Why don't we come back to you as soon as we can, Tom?

Senator CARPER. Yes, that's good.

The CHAIRMAN. Okay; we will do that.

Senator Toomey is next, and he is on the web.

Senator TOOMEY. Thank you, Mr. Chairman. Can you hear me okay?

The CHAIRMAN. Perfectly.

Senator TOOMEY. Okay; thank you. Mr. Secretary, welcome back.

You know, back in February of 2020 we thought the bottom was going to fall out on State tax revenue. And so Congress increased the FMAP for Medicaid, the Federal Matching Percentage, by 6.2 percentage points across the board. Of course it is worth reminding everyone that, when Congress does that with a Federal contribution, it does not help beneficiaries or health-care providers. It does not change benefits or payment amounts to them. It simply results in States paying less for the same expenditures that would have occurred anyway, and the Federal Government pays more for those.

Now it was, as I say, intended to deal with the risk we perceived that State revenues were going to be extremely hard-hit by the COVID shutdowns. But in fact it was very poorly targeted. The biggest benefits go to States simply with the most generous Medicaid programs, irrespective of any impact of COVID. The main drivers of how much a State would benefit from this would be the percentage of Medicaid enrollees in that State, and the spending per Medicaid beneficiary. In addition to that, and more fundamentally, of course we were wrong. Happily, we were wrong. State governments did not have a collapse in revenue. In fact, they had all-time record highs in tax revenues in 2020. And that is without considering the hundreds of billions of dollars we sent them in 2020. And then our Democratic colleagues said, "Let's send them another $350 billion," back in March I think it was, of this year, which we did.

And you know what is happening with States. Your State of California has got so much cash it is sitting on, it does not know what to do with it. It is literally sending checks out to people, irrespective of need. New York is looking to send checks to people, including illegal immigrants—why not?—they have so much money.

Well, the fact is that this enhanced FMAP is costing Federal taxpayers over $3 billion per month. And it will continue under the statute as long as the public health emergency is declared.

So here is my question. If the administration does not end the public health emergency in July—which is another entire ques-

tion—would you agree that at least it makes sense to end this policy that is extremely expensive, extremely poorly targeted, and as it turns out, given the record-high State revenues, was never actually necessary in hindsight?

Secretary BECERRA. Senator Toomey, it is great to see you. Let me—you posed some really good questions, and I hope we have an opportunity to discuss this further, because with FMAP and the whole Medicaid program, it is crucial that we get these things right. But on the first question about the public health emergency, I think it is important to segregate that, because I——

Senator TOOMEY. I do not have much time, so if we could, I would love to avoid a discussion about the public health emergency and whether or not it gets extended, and focus just on this particular policy of the enhanced FMAP.

Secretary BECERRA. So first I think I and many others would thank the Congress for taking action swiftly to make sure that States and communities did not go under. We are now seeing the recovery from COVID.

Whether or not there is a change in the policy with regard to FMAP, we are willing to work with you. But that is going to be a decision that Congress makes on where we go with FMAP moving forward. We are going to go ahead and implement the law, as you all saw fit. And what we hope is that we can continue to see more Americans get the coverage they need for their health.

Senator TOOMEY. So, I hope I can understand that to mean that you are open to ending this extremely badly targeted, extremely expensive, and totally unnecessary policy, because I think that is where that should go.

One last question here—I think I am going to run out of time. One of the exacerbating factors in this FMAP situation is the massive estimated improper payment rate. According to government auditors, the estimated improper payment rate in Medicaid is 21 percent—really, completely unacceptable.

So not only are States receiving money they do not need because they are awash in cash, but they are receiving money with respect to payments that in many cases should never have been made in the first place. That is how bad this is.

So here is my question. Could you commit to providing the State-by-State estimate of the improper payment rates, including a breakout of the eligibility component in that—because not all improper payments are driven by ineligible beneficiaries, but we need this information in order to reduce an unacceptably high improper payment rate. Would you commit to providing that data?

Secretary BECERRA. Senator, I will commit to work with you to make sure that the data that we have available that is releasable, we will try to make available to the committee where possible.

Senator TOOMEY. Would there be some kind of data you have that it is not releasable for the Senate?

Secretary BECERRA. I do not know that, and I would have to check. I do not want to promise you something that I cannot give you, but I will do everything I can to make sure we get back to you and respond to that question.

The CHAIRMAN. The time of the gentleman has expired.

Senator TOOMEY. Thank you.

The CHAIRMAN. Two points. We are going to go back to Senator Carper. But I would also like to remind Finance members that we have votes on four Treasury nominees. They will be off the floor during the upcoming votes. So please go to the hallway outside the President's Room to vote on those nominees. We have only a handful of Senators here now, so staff will also spread the word.

So now I believe we have Senator Carper rejoining us, and he believes that he is going to be able to get through. Senator Carper, how are we doing?

[No response.]

The CHAIRMAN. That tells me how we are doing. Senator Carper?

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. Secretary Becerra, it is good to see you. I want to start with prescription drugs.

I know the chairman mentioned that as the first thing off the bat today, the high cost of prescription drugs. And Senator Stabenow mentioned it, and I agree with that. So I want to go from a different perspective, and that is, drug shortages.

We have high-cost prescription drugs, and then we have drugs that are not terribly expensive that are not available because the profit motive is not there. And as a result, we have extremely important drugs, some used to deal with cancer treatment, that are not as available as they should be.

I was happy to see the President's budget included $22 million for a new resilient supply chain and shortage program. Could you just share with us how those funds, if appropriated by Congress, would be used to deal with this drug shortage issue?

Secretary BECERRA. Senator, what we are hoping to do is find that we have always a stockpile, that we are better prepared, that we are telegraphing where things will go. In my opening statement, I mentioned how we are right now in the process of preparing for the next pandemic, the next health crisis. And so in addressing that, one of the things we will have to do is make sure we have the medicines necessary to address that. So we are going to try to do what we can to try to boost the supply, including, if possible, through domestic manufacture of that supply.

Senator CARDIN. And we have had bipartisan support on this committee, and in the Senate, to deal with the drug shortages. Will you commit to work with us as you develop the strategy to make sure that America has drugs available for its population, and we are not in drug shortage because of the supply chain issues?

Secretary BECERRA. Absolutely. And in my work as Attorney General in California, we fought against the types of collusive arrangements that were often made by the industry to avoid putting more of that product on the market.

Senator CARDIN. Thank you.

I was the author of the Prudent Lay Person Standard when I was in the House with you in regard to emergency care, to make sure that a person who has the symptoms that require them to go to an emergency room will be reimbursed even if the final diagnosis was not an emergency circumstance. The symptoms would lead a prudent layperson to seek urgent care.

In 2018, I asked Secretary Azar at the time to look at potential violations by Anthem in regards to their policies. Well, it surfaced

today that it looks like United Health Care is also using a program that could violate the Prudent Lay Person Standard.

And I am concerned we could see an erosion, if we do not have the strict enforcement, so that individuals who should be seeking urgent care are hesitant because they are concerned as to whether their health insurance will cover that cost. Will you be aggressive in this matter?

Secretary BECERRA. Absolutely. And I am hoping that the more we see Americans sign up for health care through the Affordable Care Act, that fewer people will be reluctant to use the ER.

Senator CARDIN. I hope so. But we have just got to be careful that when they say that they are not going to pay the bill after the fact, and then maybe they could win in appeals, et cetera, unless there is clear direction to use urgent care when it is needed, we are liable to lose some people who are hesitant to go to emergency care. I just urge you to be aggressive in this and not let the insurance carriers carry the day. We were very clear on the Prudent Lay Person Standard.

Secretary BECERRA. I look forward to working with you on this.

Senator CARDIN. Then on minority health and health disparities, President Biden has been very clear about his commitment to deal with historic challenges we have had. Included in the Affordable Care Act was the National Institute for Minority Health and Health Disparities that I authored. I was pleased to see that the President's budget includes an increase of $261 million for the National Institute for Minority Health and Health Disparities. Could you tell me more about the importance of expanding HHS's investment and research to address longstanding inequities?

Secretary BECERRA. Senator, first, thanks for all the work that you have done on this. And as you have mentioned, we are going to put real money behind this effort. What that will produce, I think, are not just lives saved but better outcomes for kids in the future. The fact that, for example, in America we still have pockets where women often die delivering a child, that our maternal mortality rates are out the roof, higher than any other industrialized nation—we are putting money behind efforts to try to address that.

We are going to do everything we can to put equity at the front of everything we do and think about when it comes to health care. But we look forward to working with you, because there is some real money—and thank you, by the way, for the help during the American Recovery Plan to make sure that we have resources to get behind that.

Senator CARDIN. Well, thank you. I will just conclude by acknowledging that your budget includes an expansion of Medicare for dental, hearing, and vision. I have been pushing for particularly the dental aspect to that. There is bipartisan support here again, and we look forward to working with you in that regard.

Secretary BECERRA. Thank you.

The CHAIRMAN. Thank you, Senator Cardin. Our next two questioners will be Senator Grassley, and then Senator Menendez.

Senator Grassley?

Senator GRASSLEY. I know that you have a big interest, and President Biden has a big interest, in reducing drug prices. There are a lot of Republicans in the United States Senate who want to

do it. And I would conclude that if President Biden and his staff feel it can be done by reconciliation, then I think that I would quit talking and not ask any questions.

But if they would come to the conclusion that possibly some of the things that are being talked about on the Democratic side cannot get 60 votes in the U.S. Senate, I think it would lead you to the work that Senator Wyden and I have done over the last 2 years on reducing the price of drugs, and probably could easily get 65 to 70 votes in the U.S. Senate, and maybe even more than that. We did have 10 House Democrats who wrote to Speaker Pelosi worried about getting something done on prescription drugs, if it was not a bipartisan prescription drug bill.

So that kind of brings me to this dialogue with you. Can I infer from the fact that the President's budget does not assume passage of H.R. 3, that the administration accepts that there is no path forward on H.R. 3? Would you be willing—if that is something you might agree to, would you recommend to President Biden that he instead focus efforts towards supporting a bipartisan bill that can get 60 votes in the United States Senate and then get something done big time in this area, because big pharma does not like what Grassley and Wyden have been working on for 2 years?

Secretary BECERRA. Senator, first, thank you for all the work that you have done with the chairman to try to get this done. I think we are anxious to work with the two of you, and members on both sides of the aisle and in both chambers, to try to get something done.

The President has said plainly that he wants to get behind some reforms to reduce drug prices. He has said he is open to and supports negotiating prices. He has said he supports the idea of seeking rebates when prices are too high. And I think what the President has signaled in his budget is that we are open to make sure that what we end up doing is reducing the price of prescription drugs for Americans. And so, we look forward to working with you and all of your colleagues to get something done.

Senator GRASSLEY. On another item, I worked with Senator Warren for over 4 years to provide access to over-the-counter hearing aids. Since the 2017 law passed, the FDA has not issued regulations to establish an over-the-counter hearing aid market. By the way, I hope Senator Warren did not bring this up. If she did, I do not want to——

The CHAIRMAN. Senator Warren has not brought it up, but I have known that you and she have this important bill, so go ahead.

Senator GRASSLEY. Okay. Well, I did not want to take time if she had done that. Anyway, since the 2017 law passed, the FDA has not issued regulations to establish an over-the-counter hearing aid market.

Recently, the FDA authorized Bose to sell its over-the-counter hearing aid products, but there is no market for Bose to sell its product. So my question to you is, can you provide a timeline on FDA issuing over-the-counter hearing aid regulations? If not, what is the current status of a draft regulation? And what barriers are there to preventing FDA from issuing regulations in that area?

Secretary BECERRA. Senator, I know that we are in the works. I asked about this myself. I asked because my mother asked me

when we were going to deal with this, because she is one of those victims of those hearing aid commercials, and so forth, and she is fed up with what happened with her. And she is out some money. But I will tell you this: we are trying to work diligently to put this regulation out there.

We know millions of Americans will benefit if we can help them make sure they are good consumers of hearing aids.

Senator GRASSLEY. This is something—this will have to be my last question. I have written two letters, March 8th and May 26th, to the Department asking what, if any, oversight was done on the virus grants that Dr. Fauci's unit sent to EchoHealth Alliance. I am going to skip some of that intro on that question.

Did the Department—so here is the question—did the Department of Health and Human Services specifically identify Dr. Fauci's unit? Did you do any oversight of the taxpayers' money sent to the Wuhan Institute of Virology? If so, can you say with certainty that the money was not misused by the Chinese Government? And if no oversight was done, please explain, if that is the case.

Secretary BECERRA. Senator, thank you. And as you know, the principals at the NIH, and obviously Dr. Fauci among them, have made it very clear: the NIH never approved of funding for the Wuhan Institute of Virology. And what we are doing is continuing the accountability work that is out there that the President has called for. I made a call for that about a month and a half ago. And I think you all are now making a call for that in this recent legislation that came out of the Senate to make sure we get to the bottom of this.

And so, at the end of the day, I think we are going to get to the bottom of how things happened with regard to this coronavirus. But I can guarantee you that the NIH never approved any money to go directly to the Wuhan clinic.

The CHAIRMAN. The time of my colleague has expired.

Senator Menendez?

Senator MENENDEZ. Mr. Secretary, good to see you. I did not intend to talk about this, but I just want to make a point that when we talk about prescription drug reform, there are many ways to try to seek it. What I am concerned about is, I consistently see that we take revenue from the pharmaceutical industry, but we do not lower the cost of prescription drugs. So I do not quite get it, that if you keep taking revenue from the industry but you do not lower the cost of prescription drugs, how does that help the consumer?

So for me, the bottom line is going to be: show me how you are going to lower the cost for consumers on prescription drugs, and do so in such a way that—and we just saw in the midst of this pandemic how important this industry is to produce a life-saving vaccine. So I think we have to get our priorities right in that regard, and that is going to be my bottom line.

Let me ask you something. While official 2020 data on all gun deaths is not yet available, every analysis of data from the Gun Violence Archive shows that gun-related deaths in 2020 will likely exceed 40,000, a rate of 12.3 gun deaths per 100,000 people. This translates to the highest rate of gun deaths in the last 2 decades.

So my question to you: do you believe that gun violence is a public health epidemic?

Secretary BECERRA. Senator, of course. And I agree with the American Public Health Association that believes it is a public health issue as well.

Senator MENENDEZ. As such, will you commit to ensuring that the CDC funding is used to study gun violence as a public health epidemic?

Secretary BECERRA. Not only will we commit to that, but we are asking for funding to make sure we can do this well.

Senator MENENDEZ. All right. I look forward to supporting that.

Now, as you and I had discussed before in this committee, our country is facing a projected shortage of up to 124,000 physicians by 2034. Increased Federal investment in physician training is a key piece of helping to address the physician shortage. And prior to the end of last year, Medicare support for GME had been effectively frozen for nearly 25 years, a quarter of a century.

My bipartisan legislation, the Resident Physician Shortage Reduction Act, will build upon the 1,000 Medicare-supported GME slots that I secured last year by providing another 14,000 targeted slots over 7 years.

So, looking at the needs of our population, how will the 1,000 slots that Congress provided last year, in addition to future additional training slots, address the physician shortage? And how will you ensure their expeditious implementation?

Secretary BECERRA. First, Senator, thank you for that work. I think those of us who have—when I represented that community in the past as a member of Congress, we too fought to preserve those residency slots in areas of need. And so what we are going to do is, we are going to go out and talk to the provider community to make sure that we know exactly where there are shortages.

We are going to try to encourage a lot of incoming physicians to consider working in those areas of shortage in rural areas, in low-income communities, and we are going to try to make sure that the residency slots will be there to meet them when they are ready to come work in those areas that need new physicians.

Senator MENENDEZ. All right. Well, we look forward to working with you on that.

We are finishing twin pandemics of pervasive racism and COVID–19, which have laid bare health inequities facing many minority communities. According to the CDC, women of certain of these communities are two or three times more likely to die from pregnancy-related causes than white women. The budget proposes some significant investments in addressing the maternal mortality, which is great, but how specifically do you plan to combat the crisis, including reaching and working with these at-risk communities? And what workforce investments have to be made to improve maternal mortality?

Secretary BECERRA. Well first, you all helped us tremendously with the American Rescue Plan, and you made some funds available for us to target some of this. We are focusing a lot on maternal health, because it is embarrassing to say that the richest country in the world has some of the worst outcomes when it comes to maternal mortality.

We have an investment in a program called the Improving Maternal Health Initiative which would help us go into these communities where we see mostly women of color being the ones who experience the terrible outcomes, in some cases including death. And if we are able to, with your help, secure passage of the American Families Plan, we will have an additional investment of some $3 billion to really target communities that have been left behind.

Senator MENENDEZ. All right.

And finally, the President's budget supports eliminating the current Medicaid funding structure for territories, and proposes treating our citizens, U.S. citizens who live in the territories, the same as citizens living in States. Will you commit to working with me and the committee—I am thinking about Puerto Rico, but it is not the only one—on a path forward for parity?

Secretary BECERRA. Senator, I absolutely look forward to working with you. The President has made it very clear, every American citizen should have access to quality health care, regardless of where you live, what your ZIP code might be.

Senator MENENDEZ. Thank you.

The CHAIRMAN. I thank my colleague.

I think we are going to see if Senator—let's see. Senator Cantwell is here in person. Senator Cantwell, would you like to go next, because you are here early?

Senator CANTWELL. Thank you. Mr. Secretary, good to be with you.

Obviously, one of the concerns we have moving forward on health care, as we have expanded access to care which we saw was so important during COVID—but pre-COVID we still had issues of affordability. What are your ideas for how we put more affordability into the system?

Secretary BECERRA. Well, we continue to improve the Affordable Care Act versus trying to dismantle it. That would be one of the best things. We have seen how Americans, when given a choice, when they see what their options really are, will sign up. We have had over a million people sign up to get new coverage under the Affordable Care Act in the last few months as a result of the President's special enrollment period.

We are now at 31 million Americans who have taken advantage of the Affordable Care Act and today have coverage as a result. And so, if we can continue to expand coverage, what we will find is that we will be able to provide it at a more affordable rate, instead of watching people walk into an emergency room to get their primary care services.

And so there are any number of ways we can continue to extract greater cost efficiencies as we continue to expand care, and we are looking forward to working with you on some of the ideas that I know are percolating in Congress to make that happen.

Senator CANTWELL. So, you know I am a big fan of the basic plan, which New York implemented, so a $500 annual coverage for a family of four, versus what you would have in the Silver Plan, so $1,000 in savings. So I am a big fan at least at that income level, expanding the market because, you know, I keep trying to explain it as the Costco model, because you are buying in bulk and

they are giving you a discount, both on prescriptions and for health care. So we are a pretty big fan of that.

I also wanted to bring up—we feel that we need to continue to drive down costs as we have expanded our access to telemedicine. So not only do we need to do our side on the broadband expansion to make sure that the telehealth can be delivered, but we also need to get the right reimbursement rates.

How do you suggest we should look at that so that we can get the actual system to expand more into telemedicine?

Secretary BECERRA. So COVID–19 taught us a great deal on telemedicine. And what we are finding is that the more flexibility we offer, the greater the chance that something like telemedicine will be used, and used well.

We need to have some basics in place. We have to make sure that broadband is available in all communities. We do not want to leave people behind simply because broadband has not caught up to them. But we know that once you have access to good technology, then it is a matter of making sure we can implement in ways that make sense.

In some cases it will be virtual, with video. In some cases, it might be just audio. We want to be flexible, but we want to extract accountability. We want to make sure that if we are going to extend something like telehealth and telemedicine, we are ensuring that, at the end of the day, we are getting real value for the dollars we are providing for that service. So accountability will be crucial.

Senator CANTWELL. I think there is real value here, and I am happy to work with you and others at the University of Washington, which has been a leader in this. And we think there are efficiencies and savings.

Another area of efficiencies and savings is in the area of home health, the money follows the person concept. My colleague, Senator Portman, and I have worked on this. This is to basically allow older adults and people with disabilities to leave the institutional setting and receive community-based care. Your budget has a $400-billion investment in community-based services. So we appreciate that. But we think we have to continue to move forward on having established community-based health-care services for individuals, and delivering that care at home.

Secretary BECERRA. You had me at "hello" on that. My father died in my home. We cared for him in his last months, and he lived with me. My mom and he lived with me for the past 4 years, and we were able to provide him the best care he could get because he was with family, and he died with his family surrounding him.

I think everyone would like to know that they can receive care, including hospice care if possible, at home. But one way or the other, we have to make sure it is good care, community care; family care, obviously, is among those.

Senator CANTWELL. Well, I am sorry to hear about your loss of your father, so my thoughts are with you. It is a tough challenge for all of us as our parents age.

One last thing that I wanted to bring up is, yesterday we had a hearing on NCAA sports issues and NIL rights. One of the things that we want to make sure of is that health-care standards are there for athletes. Some of the testimony revolved around the num-

ber of deaths in college athletics as it relates to heat exposure, and the practices juxtaposed to professional football that did not have those same numbers. So clearly people have made decisions about the environment, and so we want to work with you on what we think are health standards for our collegiate athletes. And if you could find us the right person, we would appreciate it.

Secretary BECERRA. I look forward to working with you.

The CHAIRMAN. The time of my colleague has expired. We are still going in the order of appearance, so I believe the next would be Senator Brown and then followed by Senator Casey, who has been very patient.

Senator Brown, are you there?

Senator BROWN. Yes, I am. Thank you, Mr. Chairman, for holding this hearing. Secretary Becerra, it is good to see you again. And thank you for appearing here fairly regularly. Thanks for the work you have done to implement the Rescue Plan.

Thanks for coming to Columbus recently to see some of the great work that we are doing in Ohio. We expect you, and hope to invite you back to other places around Ohio.

I want to thank you for including such robust funding for CDC in this year's budget request. As you know, the U.S. has underfunded public health for decades. The President's budget proposal to increase funding to $8.7 billion, the largest budget authority increase in the CDC in 2 decades, is long overdue.

If you would, just sort of paint the picture for us, Mr. Secretary, why this funding is so important to help prepare for future global pandemics. We essentially surrendered before by underfunding public health. What does this mean for us?

Secretary BECERRA. Senator, as you know very well, when COVID hit, even though we have the most sophisticated healthcare system in the world, we found that there were clearly pockets in America where that health care was not reaching. And the result was devastating. We have had more people die in America—we are 6 percent of the world population, but no country, including India, has suffered greater numbers of deaths.

And so, we know that we have to change that. And public health is that safety net. It is that fabric that protects us from falling through the cracks. And we know we must invest more in making sure that we are ready to deal with what is a community issue. It is not just that you caught the flu and now you just take care of yourself. No, every one of us is at risk if you catch the COVID–19 virus.

So, it is important for us build the infrastructure that public health is to make sure that we are protecting all of our families.

Senator BROWN. Well, thank you. The President's budget—let me shift to another issue. So, I was in Toledo over the Memorial Day week, and Lucas County Children's Services has been working to address issues about child welfare. The President's budget includes a new request for $100 million to address racial disparities in the child welfare system. Child protection interventions, as you know, disproportionately impact black and American Indian and brown children and families.

As I talked to some people from the Lucas County Children's Services in Toledo, they talked to me about wanting to know the

goals for this funding. What you are planning to do? And I would like you to commit to my office, and to these parents, that you will talk to us and work with us in the future funding opportunities in this space. So talk about the $100 million and where you expect to go with it.

Secretary BECERRA. Senator, the most important thing I can tell you is that we are not going to come up with the solutions, or the ways to drive the money. We are going to work with you and those local communities so that you put before us the best uses of the dollars.

We know that these inequities are out there. And we know that folks back home understand what it takes to address them. And so we want to work with the folks that you know who are the professionals who know how to do this, so when we use those monies, it is targeted and it is effective.

Senator BROWN. Thanks. And I want to raise—I probably will not use my whole 5 minutes—I want to raise one other issue. Mr. Secretary, you and I worked on this in the House together. We came up together—with you in Ways and Means and me in Energy and Commerce—with funding for children's hospital graduate medical education. The peculiarity of the way we fund that education left out children's hospitals, because the dollars came from expenditures on seniors, essentially, or on middle-aged people, not on children.

Your budget has—I am concerned your budget has eliminated the CHGME program and lumped its finding in with that of other graduate medical education programs. We had started this in the mid-90s. It has worked. Every President has tried to underfund it. We have restored it.

But I would like for you, if you would, to say something positive to this committee about the importance of children's hospital graduate medical education and the training that we have done well in this country for the last 25 years.

Secretary BECERRA. Senator, I think, as you remember, for 24 years when I served in the House, Los Angeles Children's Hospital was based in my district. And I saw some of the miracles that were performed there by the people at the children's hospital.

We are not going to—I commit to you this—we are not going to let those who care for our kids suffer because of the way that we sometimes distribute the slots for medical education. We have to continue—and we know this, that we need to provide more physicians in areas of primary care, children's care, and some of the specialty cares. So I commit to you that, at least under my watch, we are going to do everything at HHS that we have to do to ensure that we provide for the funding of graduate medical education to make sure we have the physicians we need.

The CHAIRMAN. I thank my colleague. And again, we are going by order of appearance, so we can get three more in at least before the vote: Lankford, Bennet, and Casey. I might want to tell my colleague from Pennsylvania, I know he has been very patient, but that is the order of appearance.

Senator LANKFORD. Thank you, Mr. Chairman.

Mr. Becerra, it is good to see you, and good to be able to check in with you again. I sent a request to your office that I have not

received a reply on, so I just want to be able to remind your team of a request. It deals with the unaccompanied children coming across the border, and some of the data that we have requested. We know this is data that is collected. I have been down to visit, in three different areas, some of the HHS facilities along the border in the last 3 months. I know all this data is collected, but we are not able to get access to it.

For instance, the number and percent of category 1, 2, and 3 sponsors for the UACs; the ages of the UACs. There is a record that is kept of how many have been sexually assaulted on their journey, and how we are providing medical care for those. None of those things we have been able to get access to that we have made numerous requests for. Can you help us actually get that done? We are not asking for extraneous information that is not already collected. We are asking for the information you already have.

Secretary BECERRA. Senator, let me get back to my team and find out where that request is on your letter that you sent us.

Senator LANKFORD. That would be very helpful; thank you.

At your nomination hearing, you and I talked about conscience and freedom, and freedom of faith, all those protections that are there. I was surprised to see the language in the budget had stripped out much of that language that had existed in previous budgets about freedom of conscience, freedom of religion. And it also seems that you are eliminating the Conscience and Religious Freedom Division. Is that true? In your budget, are you eliminating the Conscience and Religious Freedom Division?

Secretary BECERRA. We are going to continue to do the work to protect the religious, civil, constitutional rights of all Americans under HHS's purview. And we are going to continue to be a solid organization, through the Office of Civil Rights that we have, to make sure that we are protecting everyone's rights, including religious conscience rights.

Senator LANKFORD. But you are taking away that division as a priority and putting it under something else? Or where is it going?

Secretary BECERRA. It continues to function. The work continues to be functioning under the Office of Civil Rights.

Senator LANKFORD. Okay, so it has not changed? Or it has changed?

Secretary BECERRA. The work will not change. I mean, we continue to have a responsibility to protect the religious freedom of all Americans when it comes to any of the health-care programs that are out there. We will continue to provide protections for the civil and constitutional rights of all Americans, including those that involve religion. And so nothing there changes.

Senator LANKFORD. Okay. We will follow up on that in the days ahead to be able to see how that office moves, and how that shifts. I also noticed you changed a term in your budget work. You shifted from, in places, using the term "mother" to "birthing people" rather than "mother." Can you help me get a good definition of "birthing people"?

Secretary BECERRA. Well, I will check on the language there, but I think if we are talking about those who give birth, I think we are talking about—I do not know how else to explain it to you other than——

Senator LANKFORD. I was a little taken aback when I just read it and saw it, that the term "mother" was gone in spots and it was replaced with "birthing people." And I did not know if this was a direction that you were going, if there were shifts or regulatory changes that are happening related to that, or what the purpose of that is.

Secretary BECERRA. I think it is probably—and again I would have to go back and take a look at the language that was used in the budget, but I think it simply reflects the work that is being done.

Senator LANKFORD. I definitely get that. I would only say the language is important always. We do not want to offend in our language. I get that. But would you at least admit calling a "mom" a "birthing person" could be offensive to some moms, that they do not want to get like a "happy birthing person" card in May? I mean, can you at least admit that that term itself could be offensive to some moms?

Secretary BECERRA. Senator, I will go back and take a look at the terminology that was used, and I can get back to you. But again, if we are trying to be precise in the language——

Senator LANKFORD. "Mom" is a pretty good word. That has worked for a while, and I think that it is pretty precise as well.

In 2015, NIH paused funding for the human/animal hybrids chimeras—and you are familiar with the term—and had done research back before that, and you are aware that China is now advancing in chimera work.

In 2015, NIH paused and said, "We are not going to do that." Is NIH going to continue that moratorium or are you going to lift the moratorium and attempt to use tax dollars, Federal tax dollars, for chimera research here or to fund chimera research in other countries?

Secretary BECERRA. So I know that NIH has taken a close look at where it is placing its money, the type of research that is being used. I think you will understand and respect the fact that we give NIH a great deal of latitude because they take action based on the science, not on the politics. And so you will understand when I say to you that what NIH will do tomorrow is not because the Secretary of Health and Human Services has told them to go in a particular direction, it is because the science takes them there.

And we can make sure we give you a better response more directly by NIH on where they plan to go. But I would not want to infer to you that I could—that I will dictate to NIH what they will or will not do.

Senator LANKFORD. Please. We would be glad to get that information back, because this is not just science; this is an ethics and moral issue as well.

The CHAIRMAN. Colleague, thank you. With the thoughtfulness of Senator Daines, we will go with Senator Bennet, Senator Casey, and then Senator Daines. We are going to do all that before the vote.

Senator Bennet, on the web.

Senator BENNET. Thank you, Mr. Chairman. And, Secretary Becerra, it is great to see you. Can you hear me?

Secretary BECERRA. I can.

Senator BENNET. Great. Then I hope you and your family are well, and that you are settling into your new role. The last time you were here we spoke about the importance of a public option that would finish the work of the Affordable Care Act. And I am thrilled that the budget makes the changes we made in the American Rescue Plan to the premium tax credit—made those changes permanent. And as you know, this is an important provision in the Medicare Choice Act, my bill with Senator Kaine, to create a public option.

In Colorado, we have seen premium decreases as a result, anywhere from 17 percent, even much more than that, depending on where people live. For example, a family of four in Summit County, CO are going to see average savings of $151 a month, which is a tremendous accomplishment. And that is why we should make these credits permanent, to allow for continued savings for America's working families.

I am really concerned that, without establishing a public option alongside these credits, there will be many Americans who will not have a quality plan offered in the area that they live. Many of those are rural areas, but not only. In Colorado, there are 10 counties where there are no plans, or only one plan in the individual market. This obviously reduces quality and competition and increases costs.

Could you discuss your views on a public option, and provide a timeline on when we can begin working in earnest together on refining our proposal?

Secretary BECERRA. Senator, thank you for the question. Actually, my views on the public option are fairly well known. When I was a member of the House, I was active in those issues on the public option, and in my votes.

Certainly President Biden, who is perhaps the more important person to concentrate on here, has said he is very supportive of a public option as a way to help reduce the cost of coverage for all Americans. And the President has said he is very open to working with the House and Senate to try to come up with a solution which could include the public option. And we look forward to working with you and other members who have been trying to formulate a good plan that could get votes.

I will simply tell you that, on the cost side, the public option has been shown—whether it is through the Congressional Budget Office or the Office of Management and Budget, the score keepers for the Congress and for the executive—to produce savings. And as you mentioned, what we want to do is provide greater access. The public option is one of those opportunities that gives Americans a great chance to get coverage at a lower cost.

Senator BENNET. I hope we will work on it. As you know, the President ran on this. And you are right, you are absolutely right: it saves the Federal Government money while creating universal health care through a choice that every American can have.

I mean, I think this would be an extremely successful initiative, and a popular one with the American people, especially after the pandemic. So anything we can do to help with that, I would hope you would let me know.

Let me, in the last couple of minutes I have, turn to another part of your budget. The budget includes $400 billion in funding for home and community-based care through the American Jobs Plan, which will transform the way that we care for individuals in their homes and communities. This funding, through Medicaid, will take care of the most vulnerable Americans, especially children and youth, and this type of care was absolutely critical in Colorado over the course of the pandemic.

I am concerned with the increased rates of mental health illness that young people are experiencing, leading to death by suicide, substance abuse, or other mental and behavioral health challenges.

How should we use this funding to help address these mental health challenges? And how can mental health be integrated in home and community-based services for children receiving these services?

Secretary BECERRA. Senator, I know that there are a lot of folks back home in Colorado, and in my State of California, and throughout the country, who would chime in and tell us what has worked, the best practices. But what I will tell you is this. The closer we get to someone's home, their family, in providing that service, the more likely we will see success. The more you farm out people to these institutional settings, I think less caring, it seems, and less loving care would be provided.

So I think the home and community-based setting is crucial. And to the degree that we have innovative programs that are out there that we can help support, I think that is what we will try to do at SAMHSA. Working with folks that you know back in your home State, I think we will try to do the best we can, not just in Colorado but throughout the country. But really it is pretty straightforward. It is not rocket science to try to provide the treatment that people need as quickly as you can, hopefully to prevent things from getting worse, and to try to do it with someone who is as dear to that person as possible, to make it a loving setting. And then to try to make sure that you are implementing some of the innovation that is out there, providing resources to those who have shown a different way that is working well for others.

The CHAIRMAN. The time of the gentleman has expired.

The very patient Bob Casey, and then Senator Daines, also patient.

Senator CASEY. Mr. Chairman, if I cut my time in half, can Senator Warren go after?

The CHAIRMAN. We are going to do our best, because you all have been such good sports.

Senator CASEY. I will try to keep the first question brief. Mr. Secretary, it is great to be with you. You have been asked a couple of times about home and community-based services, which are a huge priority for me, but more importantly for the people who will benefit from them: seniors, people with disabilities, and of course the workforce who does heroic work.

You have your own personal experience with your dad, so I know you understand the necessity of it. I am not going to ask you a question. I just want to commend the President and the administration, and you and others, for making it such a priority. I would just highlight one individual in my home State in Lancaster Coun-

ty, Katelyn Montanez, who has provided care for her father Louis, who has had younger-onset Alzheimer's. She is one of those great examples of a family caregiver out there who is doing that important work.

For so many families, home and community-based service, just like child care, is their bridge to work. They may need a bridge, a physical bridge to work, but the bridge to work for so many families is home and community-based services. So we have to get that done as part of the caregiving infrastructure.

I wanted to ask you about junk plans. I know that the administration has included on the order of $163 billion in the budget to help Americans access affordable health care. These dollars will permanently extend changes that were implemented in the American Rescue Plan to provide access to health insurance for about 3.6 million more Americans.

I applaud these changes and improvements to the ACA. But I am also concerned that Americans understand the options that are available to them. In 2019, my office conducted an oversight report on online ads for health insurance, finding that consumers who search for insurance online are at risk of being funneled into a non-ACA-compliant junk plan by misleading ads that appear in some search results.

I know the administration is committed to defending access to quality affordable care, particularly your efforts to reinvest in ACA enrollment and outreach efforts. I would like to see what more steps we can take to protect consumers.

Mr. Secretary, could you talk about ways in which the fiscal year 2022 budget request will support efforts to protect consumers from misleading ads?

Secretary BECERRA. Senator, thanks for the question and your work on this issue. Perhaps the most important thing we can do is prevent consumers from ever applying for or paying for any of these junk insurance plans. And that is why we are putting in an investment of some $80 million into the Navigator program, which helps people understand the plans that are out there, what plans actually service their needs. And so that way, when they make a decision to start enrolling and paying for a plan, they are making the right decision from the beginning.

We are also going to expand the funding for the outreach and the education that it takes to make sure that people understand health insurance and what they need, if they are a family of four, or they are a single individual, they are 20 years old, 30 years old, or they are 80 years old. Those are the kinds of things that you want to know about a person so you can direct them.

But aside from that, we are also going to do more accountability as well, to find out who those industry players are that are trying to take advantage of the American consumer the wrong way.

Senator CASEY. Mr. Secretary, thank you. I will say to the chairman, I am going to yield back some time here. I just want to—I will send you a statement about a nursing home bill that Senator Toomey and I have, a bipartisan bill, on nursing homes. But I will yield back the last minute. Thank you, Mr. Secretary.

Secretary BECERRA. Thank you.

Senator CRAPO [presiding]. Next, I am told, we have Senator Carper, who was online, and we had trouble earlier. Are you back, Senator Carper?

Senator CARPER. Yes, I am back. Can you hear me?

Senator CRAPO. Yes.

Senator CARPER. Great. Thanks so much. Welcome, Mr. Secretary.

In 2019, then-Ranking Member Ron Wyden and then-Chairman Chuck Grassley led this committee in passing bipartisan legislation, as you know, to reduce prescription drug prices for Medicare beneficiaries. The legislation also would have lowered drug prices for seniors, lowered drug prices for Medicare and Medicaid, and required the drug companies to make price increases publicly available. I spoke with you recently about your willingness to explore whether that Finance Committee bipartisan bill might be pulled off the shelf, dusted off, and maybe used as a base on which to build for future legislative efforts in this space.

I do not know if you have had a chance to think about this at all, but I would welcome your thoughts, if you have them.

Secretary BECERRA. First, I appreciated that conversation we had, and I enjoyed your thoughts. And what I would say to you is, we would like to see these projects launch, and we know that——

Senator CARPER. Mr. Secretary? Mr. Secretary, can you hear me? Hello?

Secretary BECERRA. Senator, we can hear you. Can you hear me?

Senator CARPER. I don't hear anyone speaking. I hear Sheldon laughing.

Senator WHITEHOUSE. Yes, I hear you. I do not know——

Senator CRAPO. We all hear you, Senator Carper.

Senator CARPER. Mr. Secretary? Earth calling Mr. Secretary?

Secretary BECERRA. I'm here, Senator.

Senator CRAPO. Senator Carper, can you hear me? This is Senator Crapo.

Senator CARPER. Is anybody out there?

Senator CRAPO. Senator Carper?

Senator CARPER. All right, Mr. Chairman, I am not sure what we do in this case, but this is the third time I have tried to ask this question. I am 0 for 3.

Senator CRAPO. Well, we have the Secretary here, and he is responding, but apparently, you can't hear him. Is that correct?

Senator WHITEHOUSE. It seems like the committee feed is down. I just see the clock.

Senator CRAPO. Senator Carper, I apologize, but I guess we are going to have to move on again. I apologize for this.

We are going to go to Senator Daines.

Senator DAINES. Thank you, Senator Crapo. Mr. Secretary, thanks for being here today to discuss the President's proposed HHS budget.

The proposed budget is concerning in several ways, Mr. Secretary, but I'd like to start with the omission of the Hyde Amendment, the protections that we have had bipartisan agreement on for decades. Abortion, as you know, is a violent procedure that destroys the life of innocent, pre-born children. Because of this brutal fact, every year since 1976, Democrats and Republicans in Con-

gress have banned taxpayer funding for abortion through the Hyde amendment. Even though it saved more than 2.45 million lives, which by the way is enough to fill 36 NFL stadiums, your budget calls for completely eliminating the Hyde Amendment and its protections.

Mr. Secretary, under your proposed budget, do you know how many taxpayer-funded abortions would be performed on children who can feel pain?

Secretary BECERRA. Senator, let me see if I can try to respond, because I know that this is a question that has arisen many times. We have deeply held beliefs in this regard, and sometimes we differ—and I respect that.

My job is to make sure that I follow the law. And when it comes to a woman's reproductive rights, we will make sure that we follow the law.

Senator DAINES. Regarding the law, yesterday in the House hearing, you were asked a question about, is partial-birth abortion illegal? What is your—that's a question: is it illegal?

Secretary BECERRA. What I can tell you is that women in this country under *Roe v. Wade* have a right——

Senator DAINES. Is partial birth abortion legal or illegal in the United States?

Secretary BECERRA. Senator, again, we are going to get into this technical discussion——

Senator DAINES. It is not a technical discussion, it is a question that's pretty simple. Is it legal or illegal?

Secretary BECERRA. A woman has a right to receive an abortion here——

Senator DAINES. So are you saying it is legal, a partial-birth abortion?

Secretary BECERRA. What I can tell you without question is that a woman has a right to exercise her——

Senator DAINES. As Secretary of HHS, I would hope you would understand that title XVIII of the U.S. code, section 1531, signed into law in 2003, States that partial-birth abortion is illegal. Do you agree with that?

Secretary BECERRA. Senator, I could talk to you about the legal cases that have arisen as a result of that particular statute, but what it is probably better, again, to say to you is that a woman has a right in this country to exercise reproductive choice, and we will defend that in every respect——

Senator DAINES. That does not mean breaking the law on which the code is very clear on partial-birth abortion.

Secretary BECERRA. We will never break the law. On my watch, we will never break the law.

Senator DAINES. Okay, so the question is, is partial birth abortion legal or illegal? It is not a trick question or a complicated question.

Secretary BECERRA. Senator, I will direct you, then, to the decisions that the courts have issued with regard to that particular statute, if you like. And that is why I continue to repeat to you that what is the law is the right of a woman under *Roe v. Wade* to receive reproductive health-care services.

Senator DAINES. How many late-term abortions would you fund involving children who can live outside the womb, based on your budget?

Secretary BECERRA. Senator, we are going to make sure that we follow the law and provide women access to the health-care services that they need.

Senator DAINES. Let the record reflect that the budget you have presented to Congress will force taxpayers to send a blank check to the abortion industry to pay for abortions without limit, and you do not even know how many, or what it would cost, and are not even sure if partial-birth abortions are legal, even though the code is clear, or how many might be late-term abortions on children who can feel pain and can survive outside the womb.

Frankly, this is abortion extremism. I would ask that you please follow up on the record with these figures with the budget you have proposed.

I want to shift gears and talk about the border crisis. This year alone more than 700,000 migrants, including more than 60,000 unaccompanied minors, have illegally entered the country, the vast majority of them since February. This week, Vice President Harris was in Guatemala and Mexico, meeting with leaders to discuss the root causes of migration. She was appointed by the President 78 days ago to lead the administration's response to the border crisis, yet she still has not taken a trip to the southern border.

Mr. Secretary, if the Vice President and this administration are serious about finding the root causes of migration, shouldn't you be looking at your own policies which have clearly driven this problem to an unsustainable level?

Secretary BECERRA. Senator, again, the law requires that we address the issues at the border. At HHS, again, we have responsibility for the care of those unaccompanied migrant children. I will not speak to the issues that are under the jurisdiction of the Department of Homeland Security, but what I can tell is that, if there is a child who is unaccompanied who comes across the border, it is my responsibility under HHS to make sure that we provide, for the time that that child is here—and again, I do not make the decision on whether the child is sent back or not——

Senator DAINES. Do you believe any of your policies have created incentives and been part of the problem we are seeing on our southern border?

Secretary BECERRA. We are following the law, Senator. The law was created by Congress. We are going to continue to follow that law.

Senator DAINES. Do you believe any of the changes in policy of the Biden administration which occurred the first few months of his administration, have contributed to the crisis we are seeing on the border?

Secretary BECERRA. I appreciate that the President wants us to follow the law. If we have a broken immigration system, I do not think you can blame that on the new President, President Biden. President Biden already put before this Congress a proposal to reform our immigration laws. A broken system has created what we find at the border, and we are going to continue to follow the law

we have, especially at HHS, where our care and our concern is children.

Senator DAINES. Thank you, Mr. Chairman.

Senator CRAPO. Thank you. And I am told that we might have a chance to go back and connect with Senator Carper.

Senator Carper, are you available?

Senator CARPER. I can hear all of you. The question is, can you hear me?

Senator CRAPO. We can hear you. And I think the Secretary knows your question. Would you like him to answer the one you asked before?

Senator CARPER. I want to make sure he knows it. I was saying, a couple of years ago, Mr. Secretary, this committee, led by Senators Wyden and Grassley, passed bipartisan legislation to reduce prescription drug prices for Medicare beneficiaries, lower drug prices for seniors, lower drug prices for Medicare and Medicaid. It also required drug companies to make price increases publicly available.

You may recall I spoke with you recently about your willingness to maybe explore whether or not that bipartisan agreement, which enjoyed a lot of Democrat support and quite a bit of Republican support, might be pulled off the shelf, dusted off in this Congress, and be used to build on for future legislative efforts in this space. Have you had a chance to give that any thought, and would you just share your thoughts on that?

Secretary BECERRA. Senator, yes. I appreciate the question. I have given it a great deal of thought, and we are actually working right now to try to be supportive of the work that you are doing, and certainly the work that Senator Wyden and Senator Grassley have done, so that we can try to see progress made.

There are any number of proposals that are out there. The President has made it clear he is supportive of making progress in reducing the price of prescription drugs. He has been supportive of negotiating drug prices. He has been supportive of the efforts in the Wyden and Grassley legislation to try to deal with high prices through rebates.

We are open. We are ready. We are waiting to see where you all wish to go as well. And we will be good partners as we try to help Americans pay less for their prescription medication.

Senator CARPER. Well, that is encouraging. I would urge you to be proactive. There is an option—there is a possibility we could do something again and build on what we agreed to 2 years ago.

The second follow-up question is also with respect to prescription drug prices, Mr. Secretary. The President's budget calls on Congress to pass legislation to lower prescription drug prices in part by allowing you, the Secretary of Health and Human Services, to negotiate directly with pharmaceutical manufacturers.

However, there has been debate among my colleagues on what negotiations would actually look like. And as the principal negotiator in this proposal, share with us some insights as to what kind of approaches you would take in negotiating to lower drug prices, and what authorities would you be looking to us in the Congress for to make this happen?

Secretary BECERRA. Senator, the last point you made is where I think we should start, which is that we will look to Congress to see how we can get this done. We may have ideas, and we certainly can provide technical assistance, but there are any number of approaches when it comes to how you would negotiate those prices.

H.R. 3, legislation that passed in the House last year, provides one means. Others have other ideas. All I know is that the President is anxious to work with Congress to reduce the cost of prescription medication.

Senator CARPER. Thank you so much. Good to see you.

Secretary BECERRA. Thank you.

Senator CRAPO. Thank you.

And now we have Senator Whitehouse and Senator Warren, in that order. Senator Whitehouse is online, I hope——

Senator WHITEHOUSE. I am online. Thank you very, very much. Welcome, Mr. Secretary.

I want to add to the conversation about a public option. Senator Brown and I actually wrote the original public option that we came one vote away from getting into the Affordable Care Act. And we are delighted with Senator Bennet's and Senator Kaine's activities in this space as well.

And my ask would be that when you have your team assembled to deal with the public option and look at the specifics of eligibility and actuarial solvency, that we have a meeting, that you convene a meeting with your operating people and all four of our offices so that we can get to the detailed work of drafting legislation that you and the President could support.

Secretary BECERRA. Senator, we will be available to you whenever you call.

Senator WHITEHOUSE. Do you have a team yet assigned to public option?

Secretary BECERRA. We have a team that has been working on a number of these different proposals, because we want to be ready whenever you all might launch.

Senator WHITEHOUSE. All right. Great. Okay. Well, we will organize the meeting then, and I appreciate it.

You and I have had this conversation before, and you mentioned it just now, regarding your dad passing away and how important it was to your family to have him home and to have support from the health-care system. I had, as you know, the exact same experience, and it was meaningful to me.

You also talked about local leadership and models. I just wanted to point out to you that, for the better part of a decade now I have been working on a model for end-of-life care that we have pretty well teed up in Rhode Island.

It would be approved through CMMI, because we are asking for a number of waivers that, while they may be useful—while the underlying rule may be useful in the abstract, when applied to an end-of-life population it becomes ridiculous, like the 3-day/2-night rule, or the "you've got to commit granny to the hospital to get respite care" rule. And what we want to do is to get a Rhode Island project up and going that combines all the waivers.

And I think, as you have talked about local leadership and models, this is a really important thing to me. I know that CMMI and

Ms. Fowler report to you through CMS and Ms. Brooks-LaSure, but I wanted to mention here the importance of this committee. I have worked on it for a long time. We are ready to go. The problem has been, really, turnover at CMMI as administrations change and personnel have changed.

So I have been in "Groundhog Day" with new start after new start after new start. And this is the moment when I am actually quite determined to finally land this thing after circling, and circling, and circling, and circling.

So, I urge you to let your team know that this is important to me. And I think it is a good project. And if you will take a close look at it yourself, I think you will see that this is the kind of thing that you and Ms. Brooks-LaSure and Ms. Fowler should all give a thumbs-up to.

So, I flag that for your attention, if you don't mind.

Secretary BECERRA. Senator, we look forward to working with you on that. I flagged it for my staff. We will follow up.

Senator WHITEHOUSE. Great. I have been through enough Groundhog Days on this. I hope you can appreciate that impatience comes at some point.

The last thing that I wanted to mention to you—and this is part of a much bigger conversation, I understand—is that we are hitting in 2024 Medicare insolvency for the first time. We have massive cost savings from my favorite graph that I have shown you before, and showed in the committee all the time, that occurred with the ACA compared to previous projections.

I think that has to do with a lot of the work that we did in the ACA. The unsung heroes of the ACA were in fact CMMI and the ACOs. And in Rhode Island we have two particularly stellar ACOs that are like national best-in-class. So, I am really eager to make sure that the delivery system reform effort continues. Because to the extent we can save money through the famous triple aim by improving care, improving the experience of patients, and reducing costs—not just the old, you know, bending the cost curve down, but actually reducing costs—I think we have shown we can do that. And I am a little bit discouraged that that delivery system reform emphasis does not really appear in the budget anywhere. And I really hope that this is something that we can get serious attention on from your organization to make sure that we are expanding the ACO program, expanding the delivery system reform, expanding payment reform, and making the whole health-care system more responsive to patients in ways that will actually bring down costs because it will keep people healthier.

Secretary BECERRA. Senator, I can only say that we will look forward to working with you on any number of those subjects, and it probably will bring back memories of the work that I did when I was in the House.

Senator WHITEHOUSE. So we should not take it as a bad signal, the failure to mention it in the budget?

The CHAIRMAN. I thank my colleague from Rhode Island.

The Senator from New Hampshire.

Senator HASSAN. Well, thank you, Mr. Chair. I thank you and the ranking member for this hearing. And thank you, Secretary Becerra, for being here today.

Secretary BECERRA. Thank you.

Senator HASSAN. Mr. Secretary, I am pleased to see that the President's budget requests a 50-percent increase in funding for State opioid response grants. Since 2017, I have worked with my colleagues to secure an increase in funding for these grants, including more than $86 million for New Hampshire. This funding has enabled States to begin to make progress on addressing the opioid epidemic by expanding access to life-saving treatment and services for those struggling with substance use disorder.

Earlier this year, you and I spoke about ensuring that States do not experience dramatic cuts in funding from the State opioid response program, cuts that could jeopardize critical State initiatives. Unfortunately, the Department of Health and Human Services has not provided clarity on this issue in the months since. So the continuity of funding to States remains uncertain. So let me start by asking this: do you agree that this uncertainty is problematic? And as Secretary, will you ensure that States do not experience dramatic funding cliffs in their State opioid response grants from one year to the next?

Secretary BECERRA. I absolutely agree that it would be problematic to not address this. But here is the rub: to address it, we need the funding. And that is where we hope that the Congress will act on the President's budget request.

Senator HASSAN. I hear you on the need for additional funding as the problem gets worse in some other places, but let's be clear. You have the authority to adjust these grants within your current authorization. So, let's just go through what you think you have the authority to do, and what I think you have the authority to do, so we can be clear.

Do you agree that HHS has the authority to modify the number of hardest-hit States in the State opioid response grant funding formula set-aside?

Secretary BECERRA. Senator—and again, thanks to your staff as well for working with my team. We have a number of authorities. I think it is easier said than done to say that we have the authority to make those modifications. Each of those modifications would have consequences that would impact a number of other programs and services in States as well.

Senator HASSAN. But what we are talking about is States with very modest reductions in mortality rates from the opioids having made some progress, and then the possibility of a dramatic cut really sending them backwards.

So let me tell you what I think you have the authority for, and then perhaps our staff can follow up on this. I believe you have the authority to modify the number of hardest-hit States in the State opioid response grant funding formula set-aside. I believe you have the authority to ensure that the formula avoids significant funding disparities between States with similar mortality rates. That is what we are really talking about here. And I believe you have the authority to ensure that States do not experience dramatic cuts in your year-over-year State opioid response grant funding.

So what I would like to have happen is your team to follow up with mine, if they differ with our analysis of what authorities you have.

Secretary BECERRA. We will absolutely sit down with your team, continue to sit down with your team to try to evaluate those things.

Senator HASSAN. Okay. Do you agree we need a solution to help ensure that States do not face funding cliffs in this program?

Secretary BECERRA. You can see a clear example of that in the work that we are doing to try to extend the subsidies that we are providing under the ACA for people who fall over this cliff because they no longer qualify to get those subsidies for the ACA coverage.

So we agree absolutely that these cliffs are tremendously harmful not just to the individuals, but they are harmful to the system, because regressing is not a good solution.

Senator HASSAN. Right. So understanding that you agree we need a solution, what I would like a commitment from you about today is that you will provide us with a concrete written plan to prevent funding cliffs in the State opioid response grants, and that you will share it with my office.

Secretary BECERRA. We will work with your office where we can head in that direction. Again, I do not know what the ultimate outcome will be, but we will certainly work with your staff.

Senator HASSAN. Well, what I am looking for is a commitment to provide a solution. I hope we can do it by the end of this month. And I am going to be just very frank here. You all have put forward a wonderful qualified nominee to be the head of SAMHSA. But if your nominee does not have the backing of the leadership in her department to make commitments and use the authority that is in law to prevent States from experiencing a cliff in their funding, it is going to be really problematic.

So I am hoping that we can get this ironed out and straightened out in the near future, because it would be a real shame—without the Department committing to this, what is going to happen is, we are going to play Whac-A-Mole with our capacity to deal with the substance use disorder. And I am concerned that it does not get the same level of commitment, for instance, that the COVID–19 pandemic got because of the stigma associated with addiction.

So I would really like to drill down on this, and I would really like the Department to commit to preventing these funding cliffs from happening.

Thank you, Mr. Chair.

The CHAIRMAN. I thank my colleague. We are going to do everything we can to get everybody in on this round as we deal with the second vote. I think Senator Warner is available on the web?

[No response.]

The CHAIRMAN. Senator Warner?

[No response.]

The CHAIRMAN. Senator Cortez Masto, on the web.

Senator CORTEZ MASTO. Thank you, Mr. Chair. Secretary Becerra, thank you. It is great to see you again. And let me just say this: I really appreciate our conversations we have had about the lack of access to mental health services across this country. So I am going to start there with the need for more mental health and crisis services. And I appreciate the requested increase in the amount of response grant funding to help meet the growing need.

I believe—and I know my colleagues are looking at this as well—we should be looking at funding beyond patchwork grants and ap-

propriations. We have to improve accessibility to services under the programs where Americans get their help. That is why Senator Cornyn and I have introduced the Behavioral Health Crisis Expansion Act to do just that. It would establish a continuum of coverage of crisis services, and ensure coverage of those services.

The bill is with your team right now for technical assistance. So I look forward to working with you to get this over the finish line. But let me focus on a piece of the mental health issue that I am just as concerned about when it comes to our kids.

In April, MACPAC looked at access to behavioral health services for children and youth. Their work underscored the findings in your budget that children are struggling with increasingly serious mental health challenges. And MACPAC found that in 2018, 20 percent of adolescent Medicaid beneficiaries experienced a lifetime major depressive episode and 12 percent had suicidal thoughts. Nearly 4 percent attempted suicide. So MACPAC made two recommendations, both of which can be carried out by HHS at no cost.

They suggest that the agencies at HHS tasked with caring for kids' mental health—CMS, SAMHSA, and ACF—collaborate to issue joint guidance and technical assistance to States on improving access to services. So my question to you is, does the agency have plans to carry out those recommendations? And if not, what do you intend to do to really bring the necessary services to our children?

Secretary BECERRA. Senator, thanks for your concern and interest on this issue, long-term concern and interest. You may have heard, about a month ago I announced that, within HHS, we were establishing the Behavioral Health Coordinating Committee so that we would take the various agencies involved—whether it is SAMHSA, whether it is CMS with Medicaid, whether it is the Children and Families Administration—and we are going to work together to coordinate those services so that we do this as MACPAC suggested, with one goal in mind, and not having disparate agencies doing different things. We have also got a coordinating committee within that that will focus on children and youth.

Senator CORTEZ MASTO. Secretary Becerra, thank you. That is great news. Can I add one more thing, that IT is essential? After being home and talking with, not only students but our school districts and our State department of education—and this follows up on a letter that I sent to both you and Secretary Cardona to work together to ensure that—listen, we made significant investment over this last year to various COVID relief packages, and most recently, the American Rescue Plan. And part of that money is going into our schools. And my goal is to ensure that some of that funding goes to really ensure that we are providing effective mental health support for our students.

And so my hope is that, as part of the American Rescue Plan dollars now getting distributed, working with the Department of Education, you are tracking those dollars to ensure that schools are investing in mental health support.

So my question to you: is that something that you are also looking at? And if not, I hope that you do, and that collaboration with the Department of Education is going to be key.

Secretary BECERRA. Senator, you will pleased to know that next week Secretary Cardona and I are going to be doing a joint event where we are going to try to really push on the whole idea that these investments that we are making could just be tremendously helpful for so many families and our children.

I should also mention that we are asking for additional funding within our budget for the Community Mental Health Services Block Grant to try to address this. And you are probably aware that, about a month ago, we announced a $3-billion let-out of money, half of it for mental health services, half of it for substance use disorders, to try to address the services that we need back home.

Senator CORTEZ MASTO. Thank you. I know my time is running out. I will submit the rest of my questions for the record that include so many other things, but thank you again.

[The questions appear in the appendix.]

The CHAIRMAN. I thank my colleague for her thoughtfulness.

Now Senator Warren, who has also been very patient.

Senator WARREN. Thank you very much. Thank you, Mr. Chairman, and thank you for being here, Mr. Secretary.

So President Biden's budget proposes a historic investment in the American people. When it comes to health care, the President has called on Congress to do more, especially for Medicare. Now Medicare is very popular, but it is not perfect, especially when it comes to covering the services that older Americans need.

For example, 50 percent of people aged 75 or older have a disabling hearing loss. But Medicare does not offer a comprehensive hearing benefit. It also does not cover full dental or vision services, even though 70 percent of seniors have no dental insurance, and older Americans are at increased risk for severe eye problems.

So that is why the President, as part of his budget, called on Congress to, quote, "improve access to dental, vision, and hearing coverage in Medicare."

So, Secretary Becerra, let me ask you, how would expanding Medicare coverage to include vision, dental, and hearing services improve the health and well-being of Medicare beneficiaries, especially low-income beneficiaries and seniors in medically underserved groups?

Secretary BECERRA. Well, Senator, I think, as we have discussed in the past and I think the President has made very clear, we have ways that we can expand these services, and in fact we must, because we know it is to our own benefit to provide these preventative services as early as possible to our seniors.

What I can tell you is that there are ways to pay for these additional services. We have discussed some of those as well in the past. If you were to save money on prescription drug medication by negotiating prices, or providing that the industry must provide rebates when it increases prices too quickly, you start to develop the resources you need to pay for things like providing access to dental health services, vision services, hearing services.

So, we are looking forward to working with you to make sure that we continue to make Medicare even better. And where we go, I know that will really depend on Congress, but we are ready.

Senator WARREN. Good. I am glad to hear that. I think that is terrific. Expanding Medicare to cover health conditions that affect seniors is an obvious move, and it is the right thing to do, which is why the President has called on Congress to do it.

But it is not just people 65 and over who need better access to care. There are plenty of people just shy of Medicare age who need better hearing, dental, and vision coverage, along with all the other benefits that Medicare has to offer.

President Biden's budget also calls on Congress to give people aged 60 and up the option to enroll in Medicare, a policy that some analysts predict would give 23 million people, including nearly 2 million previously uninsured people, access to the program.

So, Mr. Secretary, why is it so important that Congress follows through on this proposal?

Secretary BECERRA. Senator, for all the reasons we now know as a result of COVID. We have too many Americans who do not have any coverage, and too many Americans who do not have enough coverage. And the worst thing we can do is allow our family members who are reaching the age of qualifying for Medicare but are not quite there, who typically are going to be more at risk of suffering from a health condition, the lack of access to the kind of care that they will need.

The President, as you mentioned, has been supportive of having the public option of having those 60 and older apply for Medicare. He has mentioned on many occasions that he is open to considering so many different ideas. But what he wants is for us to get something done.

Senator WARREN. Good. I like that. I strongly agree with President Biden. Congress should expand Medicare to include vision, hearing, and dental coverage. And it should lower the age of Medicare. In fact, I think we should go lower than the President proposed to age 55.

Now President Biden also wants Congress to let Medicare negotiate payments for high-cost Part D drugs, something you referred to earlier, Mr. Secretary. But big pharma is lobbying hard to maintain the status quo.

So let me ask you, Mr. Secretary, as Congress crafts legislation to lower drug prices, the pharmaceutical lobbyists are out there fear-mongering and pressing us to pass some watered-down bill that fails to tackle drug pricing head-on. How do you think Congress should respond? Are we going to go with these half measures? Or do you think we should pass a strong negotiation bill that implements the President's agenda?

Secretary BECERRA. Senator, I think COVID–19 has taught us so many different things, and continues to teach us. And we see what happens when we are not prepared. I do not think anyone wants the American public to not be prepared to face down, whether it is a pandemic or something as serious as making sure that all of us have access to the prescription medication we need.

We will leave it to Congress, but we think this is an opportunity to make a generational change in how we do business when it comes to prescription medication.

Senator WARREN. Good. I am glad to hear that, Secretary Becerra. I agree. The time for delays, and half measures, and equivo-

cating, and industry-friendly legislating, is over. It is time for Congress to step up and put President Biden's Medicare priorities into action.

And I do not just mean some of the priorities. I mean all of them: authorizing drug price negotiation with real muscle, expanding Medicare benefits, and lowering the eligibility age. As you say, we have an opportunity here to dramatically improve the Medicare program, and we should not waste it by being afraid to take on interest groups that are profiting off our current system.

I appreciate your being here today, Mr. Secretary.

The CHAIRMAN. The time of my colleague has expired.

Senator Scott, I believe you are next.

[No response.]

The CHAIRMAN. Senator Scott, one more time?

[No response.]

The CHAIRMAN. Senator Young, or Senator Burr?

[No response.]

The CHAIRMAN. All right, let me just do one more check. Senator Warner, are you on the web?

[No response.]

The CHAIRMAN. Can staff report that any colleagues are seeking to ask questions, either on the web or in person? Democratic side? Republican side?

[No response.]

The CHAIRMAN. Okay.

Mr. Secretary, you gave us a number of pieces of positive news. Vaccinations have taken off during the Biden administration. Now half, approximately, of Americans have been vaccinated. The Affordable Care Act enrollments are up, with 30 million now covered. And the Biden administration has made a commitment to something I have been interested in since the days when I was co-director of the Gray Panthers, and that is a real seamless system of home and community-based services.

And Senator Casey has been our champion on this here in the committee, and I look forward to the day when families can really have access to a wide array of choices for their relatives. They may decide on home care. They may decide on traditional nursing home care. Some will need, for perhaps short periods of time, nursing home care that is almost like a hospital. Some will look at assisted living. But we are very interested in working closely with you on that.

Now, having mentioned what strikes me as clearly good news and moving in the right direction, we still have some very serious challenges. And they have really been highlighted by this Alzheimer's drug approval. Because here you have essentially skimpy evidence for a drug that, in one big bite, is going to cost so much that it will gobble up the Medicare Part B budget, gobble it up and then some, raising the question of course that we are going to have breakthroughs—and not something with skimpy evidence. But we are going to have scientific breakthroughs, and we want to make sure the American people can afford to actually get them, that the fruits of that spectacular work by the scientists are actually available.

Today I have been just flooded with questions with respect to the FDA nominee. And it is possible to have an acting Commissioner a bit longer. I think it is critically important that we get that nominee, because there are questions that the American people have with respect to the evidence and how we are going to make sure these medicines are affordable.

But you and I have worked together for a long time, and we enjoyed service in the Congress, and I think we know some practical steps forward. In this committee, Senator Grassley and I were able to get Senators to say that when the pharmaceutical companies are price-gouging on drugs like insulin, which has gone up 12-fold in price in recent years, and the drug is not 12 times better, they are going to lose their subsidies, and there is going to be a rebate. And I also strongly support the idea that, with Medicare and 50 million seniors, we ought to lift that restriction, and Medicare should negotiate.

Now, as I tried to find common ground with my colleagues, I talked to Senator Crapo and Republicans and Democrats alike; I welcomed their ideas here in this committee. We will work closely with you on it, Mr. Secretary, and we look forward to continuing our work with you and to build on the positive news that you gave us today, recognizing we have some very heavy lifting, particularly in terms of taking on some of the big, entrenched lobbies in health care so that we can make real changes that help people by lowering drug prices, and we will look forward to working with you in the future.

With that, the Finance Committee is adjourned.

[Whereupon, at 12:23 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. XAVIER BECERRA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to discuss the President's Fiscal Year (FY) 2022 budget for the Department of Health and Human Services (HHS). I am pleased to appear before you, and I look forward to continuing to work with you.

HHS is at the center of many challenges facing our country today—the COVID–19 pandemic, safely caring for unaccompanied children at our southern border, the overdose and addiction epidemic, gun violence, racial inequality, and more—and we are rising to meet those challenges. I am honored to be given the responsibility to lead HHS at this time.

COVID–19 has shed light on how health inequities and insufficient Federal funding can leave communities vulnerable to crises. The President's budget invests in America, demonstrates a conscious effort to address racial disparities in health care, tackles the opioid and other drug crises, and puts us on a better footing to take on the next public health crisis.

Now more than ever, we must ensure that HHS has the resources to achieve its mission and tackle these challenges after years of underfunding. The President has put forward a budget that does just that. The FY 2022 budget proposes $131.8 billion in discretionary budget authority and $1.5 trillion in mandatory funding. The Labor-HHS total is $119.5 billion, an increase of $23 billion. Investments in the budget support families in areas such as behavioral health (mental health and substance use), maternal health, emerging health threats, science, data and research, tribal health, early child care and learning, and child welfare.

To build back a prosperous America, we need a healthy America, and President Biden's budget builds on that vision while investing in the many programs housed at HHS to save lives.

PREPARING FOR AND RESPONDING TO PUBLIC HEALTH CRISES

The fight against COVID–19 is not yet over. Even as HHS works to beat this pandemic, we are also preparing for the next public health crisis. The FY 2022 budget makes significant investments in our preparedness and response capabilities.

The Strategic National Stockpile, within the HHS Office of the Assistant Secretary for Preparedness and Response, has served a critical role in the COVID–19 response, permitting rapid deployment of personal protective equipment, ventilators, and medical supplies to States, cities, tribes, and territories across the country. The budget provides $905 million for the stockpile, $200 million above FY 2021, to ensure that the stockpile is ready to respond to future pandemic events and any other public health threats while maintaining a robust inventory of critical medical supplies, enhancing visibility of the domestic supply chain, and modernizing the stockpile's distribution model. In addition, the budget provides $823 million, $227 million above FY 2021, for the Biomedical Advanced Research and Development Authority, which has supported the development of new vaccines, therapeutics, and diagnostics for the COVID–19 response. Additional resources will support improved medical countermeasure platforms that will enable quicker, more effective detection and public health and medical responses to health security threats. The budget also supports a strong public health workforce, and addresses gaps in the existing public

health infrastructure, including at the State and local levels. In addition to discretionary investments, the budget includes $30 billion over 4 years in mandatory funding for HHS, the Department of Defense, and the Department of Energy to protect Americans from future pandemics and create U.S. jobs through major new investments in medical countermeasures manufacturing; research and development; and related biopreparedness and biosecurity investments.

During this pandemic, we have seen the critical role of the Centers for Disease Control and Prevention (CDC). To ensure that CDC is well positioned to address current and emerging public health threats, the budget restores capacity to the world's preeminent public health agency by investing an additional $1.6 billion over the FY 2021 level for a discretionary funding total of $8.7 billion. This is the largest budget authority increase for CDC in almost 2 decades. A core function of CDC is partnering with State, tribal, local, and territorial entities, and this funding will enhance those partnerships. The budget will also provide CDC with additional resources to further develop and expand teams of highly trained and deployable public health experts to support preparedness at the local level.

The COVID–19 pandemic has also shown the importance of producing reliable data. Bad inputs lead to bad outputs, and without good data, CDC cannot effectively prepare for, or respond to, public health threats and make well-informed decisions to protect the American people. With funding provided in the FY 2022 budget, CDC will build upon previous investments in the data infrastructure to date and continue efforts to modernize public health data collection and analysis nationwide.

Public health threats know no borders, and CDC is working to prevent, detect, and respond to epidemic threats at home and abroad. With CDC experts embedded in countries around the world, CDC is supporting global COVID–19 response by leveraging core public health capacities and relationships built through decades of CDC global health activities. As we continue to confront new and emerging COVID–19 variants, as well as a surge of cases in India, support for CDC's work is even more important. CDC is working closely with U.S. government agencies, ministries of health, and other partners to assist countries in responding to COVID–19, while simultaneously developing and implementing adaptations to interventions for malaria, HIV, and vaccine-preventable diseases. With the President's proposed FY 2022 investments, CDC will not only address preparedness within the United States, but will also support core public health capacity improvements overseas and strengthen global health security by improving our ability to deploy experts internationally and support efforts to prevent, detect, and respond to emerging global biological threats. CDC will invest in global health security and continue to fight health threats worldwide while simultaneously enhancing domestic preparedness to address threats here at home. Domestic health is increasingly impacted by global factors and CDC's global health security efforts include conducting research to ensure efficient disease response.

The Assistant Secretary for Preparednes and Response (ASPR) and CDC investments complement preparedness activities across HHS including basic and clinical research within National Institutes of Health (NIH) and activities within the Food and Drug Administration (FDA) to advance regulatory science and mitigate potential supply or drug shortages.

While we prepare for future pandemic threats, we are also facing a public health crisis that is already here: violence in our communities. The current public health emergency has shone a light on the issue of domestic and gender-based violence. More than one in four women and more than one in 10 men have experienced contact sexual violence, physical violence, or stalking by an intimate partner and reported significant impacts. The budget provides $489 million for the Administration for Children and Families (ACF) to support and protect domestic violence survivors, which is more than double the FY 2021 enacted levels. The budget also provides $66 million for victims of human trafficking and survivors of torture, more than 45 percent above FY 2021 enacted levels.

We have also seen the devastating impact of gun violence in communities across the country. Almost 40,000 people die as a result of firearm injuries in the United States every year, while homicide is the third leading cause of death for people ages 10–24. This is a public health issue, and one that disproportionately impacts communities of color. The budget addresses this crisis by doubling CDC and NIH funding for firearm violence prevention research. The budget provides $100 million in discretionary funding to CDC to start a new Community Violence Intervention initiative, in collaboration with the Department of Justice, to implement evidence-based community violence interventions at the local level. In addition to the discre-

tionary investment for the Community Violence Intervention initiative, the budget includes a total of $5 billion in mandatory funding for CDC and the Department of Justice, beginning in FY 2023 and continuing through FY 2029.

The climate crisis has real public health impacts, and HHS's mission depends on healthy and sustainable environments. HHS thus has a major role to play in the administration's government-wide effort to tackle this crisis. HHS's investments to combat climate change in the FY 2022 budget will advance health equity, lay the foundations for economic growth, and ensure that benefits from tackling the climate crisis accrue to tribal communities, communities of color, low-income households, and disadvantaged communities that have been marginalized or overburdened. The budget includes a $100 million increase in NIH funding to support research aimed at understanding the health impacts of climate change, as well as an additional $100 million investment in CDC's Climate and Health program to support efforts to understand and identify potential health effects, including children's environmental health considerations associated with climate change and implement plans to adapt to a changing environment. The American Jobs Plan also would invest $1.5 billion to increase the resilience of hospitals and critical infrastructure, fund health emergency preparedness cooperative agreements, and build resilience including in relation to the effects of a changing climate.

CARING FOR ALL AMERICANS THROUGH HEALTH AND HUMAN SERVICES

Central to the HHS mission is the charge to enhance the health and well-being of *all* Americans. The budget invests in areas across HHS to ensure that we are equitably serving the American people. As Secretary, I will ensure that this focus is fundamental to all of our work.

A critical part of this is investing in civil rights enforcement to ensure that all people receiving services from HHS-conducted or HHS-funded programs, no matter who they are, or where they live, can receive health care free from discrimination.

The FY 2022 budget makes expanding affordable health-care access a priority across Centers for Medicare and Medicaid Services programs. A recently released report titled "Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates" shows that the Affordable Care Act (ACA) has expanded health insurance coverage to millions of Americans, and the budget goes even further. It builds on the groundbreaking reforms introduced in the American Rescue Plan Act by extending the enhanced premium subsidies that put affordable health-care coverage within reach of millions more Americans. These improvements in the American Rescue Plan Act are lowering premiums for more than 9 million current enrollees by an average of $50 per person per month. In addition, due to the COVID–19 pandemic, an ongoing opportunity to apply for enrollment in marketplace health-care coverage is available on *HealthCare.gov* through August 15th. This extension provides individuals and families a desperately needed opportunity to get quality, affordable health insurance coverage. As of May 10th, over 1 million additional Americans have signed up for health insurance through the marketplace, and an additional 2 million obtained improved benefits through the marketplace, benefiting from both reduced premiums and more affordable cost sharing.

The FY 2022 budget also expands access to critical home and community-based services (HCBS) under Medicaid, critical health-care services that allow older people and people with disabilities to live independently in their homes and communities. The budget builds on the additional Medicaid funding included in the American Rescue Plan that not only expands access to these important services but also strengthens State HCBS programs by allowing States to use the additional money to, for example, provide additional benefits, like mental health and substance use services, to beneficiaries, as well as to raise wages and provide paid leave for home care workers.

I look forward to working with the Congress to achieve the administration's goal of lower costs and expanded and improved coverage for all Americans. This includes reforms to lower the costs of prescription drugs, such as allowing Medicare to negotiate payment for certain high-cost drugs, and requiring manufacturers to pay rebates when drug prices rise faster than inflation. We will also work to improve Medicare, Medicaid, CHIP, and private insurance coverage, by pursuing changes such as improving access to dental, hearing, and vision coverage in Medicare, making it easier for eligible people to get and stay covered in Medicaid, promoting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for eligible youth, and reducing out-of-pocket costs for individuals in private insurance coverage obtained through the marketplace. The administration also supports addi-

tional public coverage options, including a public option that would be available through the insurance marketplaces. Health care is a right, not a privilege, and I will work to ensure that families across the Nation are able to secure this right.

The United States has the highest maternal mortality rate among developed nations, with an unacceptably high mortality rate for black and American Indian/Alaska Native women. Addressing this critical public health issue is a major priority of this administration, as evidenced by the American Rescue Plan's State option to extend Medicaid postpartum coverage. Building on HHS's longstanding efforts to improve maternal health, including the Department's recent Medicaid postpartum waiver approvals, the budget provides more than $220 million in discretionary funding to reduce maternal mortality and morbidity by implementing evidence-based interventions to address critical gaps in maternity care service delivery and improve maternal health outcomes. This includes increased funding to CDC's Maternal Mortality Review Committees and the Health Resources and Services Administration's (HRSA) Rural Maternity and Obstetrics Management Strategies program. HRSA also prioritizes maternal health through its title V Maternal and Child Health Block Grant and Alliance for Innovation on Maternal Health programs. As with all our public health work, collecting good data will be critical. In addition to these discretionary resources, the budget includes $3 billion in mandatory funding over 5 years, to invest in maternal health and reduce the maternal mortality rate and end race-based disparities in maternal mortality.

HRSA's work is central to our focus on serving all Americans, given their mission to improve health outcomes and address health disparities. HRSA-funded health centers provide access to care for low-income and marginalized populations, and they serve one in 11 people in the Nation. The President's budget increase to workforce diversity programs highlights HRSA's commitment to supporting health-care providers dedicated to working in underserved areas and building toward a workforce that reflects the communities it serves and is able to provide culturally relevant care.

The budget provides $670 million across HHS to continue efforts to end the HIV epidemic in the United States by working closely with communities that have high rates of HIV transmission to implement effective prevention, diagnosis, and treatment strategies, including ones that address the disproportionate impact of HIV and hepatitis C infections in tribal communities. HHS programs have already made major progress in combating the HIV epidemic. HRSA ensures equitable access to services and supports for low-income people with HIV through health centers as well as the Ryan White HIV/AIDS Program. In 2019, 88.1 percent of those served under the Ryan White HIV/AIDS Program had achieved viral suppression, a record level that exceeds the national average of 64.7 percent. HHS will build on this work to end the epidemic once and for all.

Also, directly connected to the HHS mission is the need to provide access to high-quality care, no matter where you live. HHS will continue to focus on the unique needs of rural communities. HHS administers a range of programs that address rural health, from those that serve large populations such as health centers, to those serving targeted populations such as the Black Lung Clinics Program. The FY 2022 budget serves active, inactive, retired, and disabled coal miners and their families through high-quality medical, outreach, educational, and benefits counseling services. It also provides funding to increase the number of individuals receiving training and serving in health professions in rural communities, as research has shown that providers are likely to remain in the communities where they train as residents.

HHS will also address the stark health disparities that persist in tribal communities by investing in the Indian Health Service (IHS), which serves over 2.6 million American Indians and Alaska Natives. The COVID–19 pandemic's devastating impact on tribal communities has demonstrated the real human toll of these disparities. The budget provides a $2.2 billion, or 36 percent, increase for IHS in order to take a historic step to address chronic underfunding, expand access to high-quality health care, and address critical facilities and information technology infrastructure deficiencies across Indian country. For the first time, the budget also proposes advance appropriations for IHS to provide stability for the Indian health system and parity with how other Federal health agencies are funded. I am committed to strengthening the nation-to-nation relationship between the United States and Indian tribes. To this end, the budget supports self-determination through a consultative process to consider long-term solutions, including mandatory funding, to ensure adequate and stable funding for IHS.

The budget also provides an 18.7-percent increase to the title X family planning program to improve access to vital reproductive and preventive care and to advance gender equity. Over the last 2 years, nearly half of the programs supported by title X lost providers as a result of the 2019 regulation which added burdensome restrictions inconsistent with quality care guidelines and ultimately resulted in many highly qualified, longstanding health-care entities to exit title X. The budget allows title X to not only restore highly qualified providers, but also to expand its essential services to meet increased demand as a result of the global pandemic and resulting recession. In 2019, title X-funded clinics served almost 3.1 million Americans, 66 percent of whom had incomes at or below the Federal poverty level and 41 percent of whom were uninsured. This is nearly 1 million fewer people served than in 2018.

INVESTING IN CHILDREN'S FUTURES

Our experiences as children shape the adults we become, and support in childhood can mean success in the future. As Frederick Douglass wrote, "It is easier to build strong children than to repair broken men." High-quality early care and education lay a strong foundation so that children can take full advantage of education and training opportunities later in life. The American Jobs Plan and the American Families Plan invest in school and child care infrastructure and workforce training, and ensure that low and middle-income families pay no more than 7 percent of their income on high-quality child care. These investments include $200 billion over 10 years for a national partnership with States to offer free, high-quality, accessible, and inclusive preschool to all 3- and 4-year-olds, benefiting 5 million children. The budget also invests $250 billion over 10 years to make child care affordable.

The budget also provides $19.8 billion in discretionary funding for the Department's early care and education programs in ACF, $2.8 billion over FY 2021 enacted. This includes $11.9 billion for Head Start, which helps young children enter kindergarten ready to learn. Head Start programs deliver services through 1,600 agencies in local communities, and they provide services to more than a million children and pregnant women every year, in every U.S. State and territory. In addition, the budget provides $7.4 billion for the Child Care and Development Block Grant, $1.5 billion over FY 2021 enacted, to expand access to high-quality child care for families in all corners of the country. Over a million children receive child care subsidies every month funded by the Child Care and Development Fund, and nearly half of the families receiving child care subsidies reported income below the Federal poverty level. These investments will improve outcomes for children across the country.

The budget also invests in improvements to the child welfare system, particularly to address its racial inequity. The budget provides $100 million in new competitive grants for States and localities to advance reforms that would reduce the overrepresentation of children and families of color in the child welfare system and address the disparate experiences and outcomes of these families. This funding will also give more families the support they need to remain safely together. The budget also provides $200 million for States and community-based organizations to respond to, and prevent, child abuse, over 30 percent above FY 2021 enacted.

COMBATING MENTAL HEALTH AND SUBSTANCE USE CRISES

HHS must address the public health crises associated with mental health and substance use disorders. This need is especially urgent given that both crises have accelerated during the COVID–19 pandemic. Calls to mental health helplines have increased across the country as Americans struggle with increased anxiety, depression, risk of suicide, and trauma-related disorders resulting from the pandemic. Younger adults, racial minorities, essential workers, and unpaid adult caregivers are particularly impacted. Similarly, preliminary data from 2020 suggests that overdose deaths, which were already increasing, accelerated at an unprecedented rate during the pandemic. Provisional data suggest that over 90,000 drug overdose deaths occurred in the United States in the 12 months ending in September 2020. That represents a year-over-year increase of close to 29 percent.[1] This crisis is also evolving—overdose deaths involving substances other than opioids are also increasing. HHS will ensure that our work is responsive to the needs of communities across the country.

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[1] Centers for Disease Control and Prevention. (2021). Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts. Retrieved May 6, 2021 at *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.*

The budget addresses these crises through investments in the Substance Abuse and Mental Health Services Administration.

In a historic investment, the budget provides $1.6 billion to the Community Mental Health Services Block Grant to respond to the systemic strain on our country's mental health care system—more than double the FY 2021 level. To address the undeniable connection between the criminal justice system and mental health, the discretionary request will also invest in programs for people involved in the criminal justice system. HHS will also focus on the behavioral impact of COVID–19, including on children. When children and young people face Adverse Childhood Experiences (ACEs) such as trauma, it can continue to affect them across their lifespan, so it is critical we intervene now to support their social, emotional, and mental well-being.

The budget also takes action to address addiction and the overdose epidemic, investing $11.2 billion across HHS, $3.9 billion more than in FY 2021, including $3.5 billion for the Substance Abuse Prevention and Treatment Block Grant, which has historically failed to keep up with increases in the cost of providing substance use care to America's neediest citizens. For the first time, the budget includes a 10-percent set-aside for recovery support services, a critical step for building and sustaining the Nation's recovery support services infrastructure. The block grant remains a critical source of funding for States, tribes, and territories to provide prevention, treatment, and recovery support services to their citizens. The impact of this epidemic is felt in our communities, and the budget will direct funding to States and tribes to increase community-level response. The budget will also increase access to medications for opioid use disorder and expand the behavioral health provider workforce, particularly in underserved areas. I greatly appreciate the investments the American Rescue Plan Act provided to the Substance Abuse Prevention and Treatment Block Grant, Mental Health Block Grant, and Certified Community Behavioral Health Centers, and HHS will continue to build on these efforts.

PROMOTING BIOMEDICAL RESEARCH

HHS's work is responsible for major scientific breakthroughs, and we are committed to supporting innovative science and research in order to advance the health and well-being of our Nation. As the world's premier biomedical research agency, NIH will continue to be at the forefront of scientific advancements. The budget includes $52 billion for NIH, a $9-billion increase or 21-percent increase over FY 2021 enacted. Included in this increase is $6.5 billion to establish the Advanced Research Projects Agency for Health (ARPA–H). With an initial focus on cancer and other diseases such as diabetes and Alzheimer's, this major investment in Federal research and development will leverage ambitious ideas to build transformational platforms, capabilities, and resources to speed the application and implementation of health breakthroughs and shape the future of health and medicine in the U.S.

This bold new approach will complement NIH's existing research portfolio, which is a vital contributor to longer and healthier lives, supports and trains world-class scientists, and drives economic growth. Outside of ARPA–H, the remaining $2.5-billion increase will allow NIH to continue investing in basic research and translating research into clinical practice to address the most urgent challenges, such as HIV/AIDS and ending the opioid crisis.

RESTORING AMERICA'S PROMISE TO REFUGEES

HHS plays a critical role in promoting the wellbeing of those seeking refuge or relief in the U.S. The FY 2022 budget provides over $4.4 billion to the Office of Refugee Resettlement (ORR)—an increase of over $2.5 billion above FY 2021 enacted. This funding would allow ORR to support an increase in the refugee admissions ceiling to 62,500 this fiscal year and to continue to rebuild the resettlement infrastructure in order to resettle up to 125,000 refugees in FY 2022.

This funding increase also reflects a commitment to ensuring that unaccompanied children are provided with care and services that align with child welfare best practices while they are in ORR's custody, and unified with relatives and sponsors as safely and quickly as possible. Despite significant challenges posed by COVID–19 and policies from the previous administration, HHS is humanely caring for unaccompanied children while working to unite them with a vetted sponsor. Working across government and in close partnership with the Department of Homeland Security, we have substantially increased our ability to quickly facilitate the transfer of children out of U.S. Customs and Border Patrol custody and into child-appropriate settings, including with fully vetted sponsors.

FUNDING CORE PROGRAM OPERATIONS

It is simply not possible to meet the HHS mission and address all these key changes without sufficient funding to cover our operational needs. The FY 2022 budget invests to bolster operations. It strengthens administrative and operational resources throughout the Department needed to ensure proper stewardship of resources entrusted to HHS by Congress.

PROVIDING OVERSIGHT AND PROGRAM INTEGRITY

Given the magnitude of HHS's work—and the taxpayer dollars used to fund it—it is critical that we ensure that our funds are used appropriately. The budget invests in program integrity, including efforts to combat fraud, waste, and abuse in Medicare, Medicaid, and private insurance.

CONCLUSION

I want to thank the committee again for inviting me to discuss the President's FY 2022 budget for HHS, which offers a comprehensive fiscal vision for the Nation that reinvests in America's health, supports future growth and prosperity, and meets U.S. commitments in a fiscally sustainable way. I look forward to continuing to show how HHS helps fulfill that vision.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. XAVIER BECERRA

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. On a bipartisan basis, the Senate Committee on Finance worked tirelessly to get the Family First Prevention Services Act of 2018 (FFPSA) into law so that more families could stay together and not need foster care when it is unnecessary. Congress intended the prevention services funded under FFPSA to help address the alarming overrepresentation of black and American Indian children in our Nation's child welfare system. Unfortunately, the limited number of programs and services currently rated by the title IV–E Prevention Services Clearinghouse and allowable for Federal reimbursement under FFPSA prevents States from utilizing culturally sensitive programs that are best equipped to support families of color. I was encouraged to see that the President's budget includes a new $100-million competitive grant to address racial inequity in our child welfare system.

How will this new competitive grant support FFPSA implementation?

Answer. FFPSA implementation is a key component in maximizing early supports to advance the health and well-being of families and prevent involvement in the child welfare system and HHS is focused on supporting implementation. HHS has encouraged child welfare agencies to engage in broad based planning with other child and family serving agencies in designing their title IV–E Prevention Plans. The opportunity to implement prevention services under FFPSA opened the possibility for jurisdictions to assess their service array to determine how to better meet the needs of communities, and to do so in partnership across programs, many of which are serving the same populations. The proposed competitive grant program to advance racial equity in child welfare and reorient systems towards a prevention-first model would incentivize State, local, and tribal child welfare agencies to partner with other government and community stakeholders across the education, health, human services, and early childhood sectors to implement prevention services with a focus on advancing equity in child welfare, including through culturally sensitive programs that might not yet be rated by the Clearinghouse. This budget proposal complements the goals of FFPSA and HHS looks forward to working with the committee to continue to improve outcomes for all children.

Question. What other activities or efforts is your department considering to increase the number of evidence-based programs that have demonstrated positive outcomes for families of color and to ensure States have access to FFPSA dollars for the culturally sensitive programs and services they want to use?

Answer. Ensuring that our programs have positive outcomes for communities of color and that States have access to funding to help promote and implement culturally sensitive programs and services is a priority for the Department. The Department is undertaking several steps to work towards equity in our programs and services. Part of this work is ensuring that we have rules that protect access and promote nondiscrimination in our programs and services. Further, we have the Pre-

vention Services Clearinghouse, whose goal is to review and rate as many programs and services as quickly as possible to support States' efforts to improve outcomes for children and families through implementation of the FFPSA. The Prevention Services Clearinghouse website includes the working list of programs and services that are currently under review. This information can be found on the About page of the Prevention Services Clearinghouse website.

Please note that the Children's Bureau released Information Memorandum ACYF–CB–IM–21–04 to support the need for prevention services in Indian country as native children are the most overrepresented minority population in foster care in the United States. Nationally native children are three times more likely to enter foster care than white children. Native communities have been among the hardest hit by the pandemic nationally and are suffering disproportionately with illness, high mortality rates, and economic distress. All of these heighten the need and urgency for prevention services in Indian country. The purpose of the Information Memorandum is to clarify how allowable adaptations to evidence-based programs and services that have been rated by the Prevention Services Clearinghouse can be used to provide flexibility for tribal communities under State title IV–E prevention programs, and to encourage State IV–E agencies to identify with tribes which services will be most helpful and to work with tribes to make allowable adaptations to services that will be responsive to tribal culture.

The Children's Bureau continues to receive and respond to recommendations from the field regarding the evidence-based programs that can be reviewed by the Prevention Services Clearinghouse. The Children's Bureau is also engaged in efforts that may further explore and be responsive to underserved populations to address longstanding equity issues that have been well documented in child welfare services through discretionary and formula grant programs. HHS and the Children's Bureau welcomes the continued partnership of the committee as we implement FFPSA and focus on advancing equity in child welfare.

Question. I have long opposed a harmful rule finalized by the Trump administration (RIN 0991–AC16) that would remove Obama-era nondiscrimination protections from HHS-funded grant awards (45 CFR 75.300 (c) and (d)). This final rule would allow sweeping taxpayer-funded discrimination based on sex (including sexual orientation and gender identity) and, in the case of foster and adoptive parents, religion. These regulatory changes could make it difficult for vulnerable populations, like LGBTQIA+ communities and religious minorities, from accessing vital programs and services funded by the Department of Health and Human Services (HHS). The final rule was set to go into effect on February 11, 2021, and I applaud HHS for consenting to a court order staying its effective date until August 11, 2021. Yet, at the same time as this rulemaking was announced in 2019, HHS under the Trump administration issued a Notification of Nonenforcement immediately stopping enforcement of 45 CFR 75.300 (c) and (d). To date, HHS has not rescinded the Notification of Nonenforcement.

What is your plan to reverse the Notification of Nonenforcement, initiate new rulemaking to retain robust nondiscrimination protections for HHS-funded programs and services, and eliminate other discriminatory policies in place at HHS (such as waivers for specific States to nondiscrimination requirements in 45 CFR 75.300 (c) and (d) based on sexual orientation and gender identity and on religion)?

Answer. In response to President Biden's Executive Order 13988 (Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation), issued on his first day in office, the Department of Health and Human Services is reviewing all of its regulations, policies, and agency actions that prohibit sex discrimination. Pursuant to this order and review, HHS will "revise, suspend, or rescind such agency actions, or promulgate new agency actions, as necessary to fully implement statutes that prohibit sex discrimination and the policy set forth" in section 1 of the order. The Department is happy to keep you apprised of this work as it moves forward.

Question. The Department of Health and Human Services (HHS) has begun publishing facility-level COVID–19 vaccination rates for nursing home residents and staff in response to a letter sent by bipartisan members of the Senate Finance Committee (Chair Wyden, Ranking Member Crapo, Senator Casey, Senator Scott) on March 24, 2021. HHS's decision to collect and publish this data is an important transparency measure for consumers that Senator Casey and I first called for in December 2020. However, key steps remain to make these data accessible to the public, and provide researchers a clear picture of how the vaccine rollout proceeded.

First, regarding the vaccination data that the Centers for Disease Control and Prevention (CDC) has begun collecting through the National Health Care Safety Network (NHSN) for both residents and workers, and that the Centers for Medicare and Medicaid Services has begun publishing in the COVID–19 Nursing Home Dataset. The dataset has become so large that it is unwieldly for most people to handle unless they have access to powerful computers with specialized data analysis software. The Excel file containing the data is now more than 400 megabytes, and contains more than 200 columns and hundreds of thousands of rows. I am concerned that in its current State, the dataset has been rendered nearly useless for most members of the public, and is falling short of goals laid out in the Federal Data Strategy, among which are to "design new data collections with the end uses and users in mind . . . promote wide access . . . [and] diversify data access methods," to ensure that cooperating agencies, stakeholders and the public can use the data the Federal Government is collecting.

How does HHS plan to make the raw data more readily accessible than it currently is to members of the public and policymakers who don't have the same level of computing/analytics power that a university researcher or think tank might have?

In doing this, how will HHS ensure that longitudinal nature of the files will be maintained (for example, by breaking up the number of columns by subject matter, *e.g.,* a vaccine file; a PPE/staffing shortages file; an infection/death file in addition to a master file)?

In March 2021, the Associated Press reported of continued problems with the COVID–19 data site, noting that an AP a project manager with the National Consumer Voice using the site's map had recently "put in a facility's name, and a popular chain restaurant came up," while an AP reporter "turned up an animal hospital, after entering the name of a nursing home and the community it was located in." What steps does HHS plan to take to improve the search capability of the nursing home map, which is currently the only way the public can effectively find vaccination data for individual nursing homes?

Answer. 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. I have asked CMS to review the nursing home map to improve the information available to consumers. I have also asked CMS to find both short term improvements to the data site to make vaccination data for nursing home residents and staff more accessible. It is a top priority to improve transparency, evaluation, and accountability, including increasing the available data regarding vaccinations in nursing homes. The Department will keep you apprised of these efforts moving forward.

Question. The bipartisan letter from Finance Committee members called on HHS to publicly release data, including information dating back to December 2020, that have been provided to the Federal government by CVS and Walgreens in regards to the Long-Term Care Partnership (LTC Partnership). The LTC Partnership data is the only real time accounting of the rollout, and experts have told the Finance Committee that it is critical understanding the racial, economic and geographic equity of vaccine distribution. As the letter noted, releasing such information retrospectively will help researchers and policymakers analyze issues such as the speed and equity of vaccine distribution, and the vaccine's role in reducing disease and death in nursing homes. Moreover, the HHS has been sharing the LTC Partnership data with States and used the data for its own public-facing research.

Given that HHS has refused to release this data publicly in response to the Finance Committee's request, please provide me with all facility-level vaccination data that has been transmitted to HHS by the LTC Partnership since December 2020. Please provide these data no later than July 15, 2021.

Answer. We would be pleased to work with your staff on your questions related to facility-level vaccination data.

QUESTION SUBMITTED BY HON. SHERROD BROWN, HON. BENJAMIN L. CARDIN, AND HON. ROBERT P. CASEY, JR.

Question. Currently, Medicare has a statutory exclusion on Medicare coverage of dental care and routine dental services like x-rays and cleanings. For the two-thirds of elderly beneficiaries and individuals with disabilities under Medicare, this means their access to care is incomplete.

Establishing a Medicare dental benefit has been a priority of mine for a number of years, and earlier this year I introduced legislation again along with Senators Cardin and Casey that would create a dental benefit under Part B to improve the health of our Medicare beneficiaries. We also recently wrote to President Biden urging that Medicare benefits be expanded to include dental care. I am also pleased that the President Biden's budget supports strengthening Medicare by improving access to dental, hearing, and vision coverage for beneficiaries.

What are the administration's next steps to establish a dental benefit in Medicare?

Answer. Thank you for your leadership on this important issue. Oral health is a critical part of overall health and I look forward to working with you on these issues. President Biden supports making dental coverage a standard benefit in Medicare.

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 183,000 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, those facilities that consistently fail to meet the standards of care we have set forth. 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, the standard we would expect for our own loved ones.

That is why, Senator Toomey and I reintroduced our bipartisan bill, the Nursing Home Reform Modernization Act (S. 782). This bill would ensure that every facility that qualifies for the program receives assistance and strong oversight.

Can you elaborate on the administration's proposal to put additional funding towards oversight of these poor-performing nursing homes?

Answer. The budget requests $472 million for Survey and Certification. This level of investment will strengthen health, quality and safety oversight for over 75,000 participating Medicare or Medicaid provider facilities. Survey workloads and costs are increasing due to a growing volume of facilities, serious complaints, and enforcement activities once a deficiency is identified. Further, the COVID–19 pandemic has underscored the need for the Survey and Certification program's oversight role for holding nursing homes and other facilities accountable to meeting minimum infection control standard and protecting public health for beneficiaries in these facilities from COVID–19.

Building on lessons learned during COVID–19, the budget enables CMS to make system improvements and technology upgrades, ensuring that real-time information on compliance trends and quality indicators are readily available to better target survey actions. To mitigate public long-term health risks, CMS plans to focus further on conducting in depth, proactive certification surveys that ensure quality issues are detected early, avoid patient harm, and result in less severe enforcement action over time rather than reactively responding to complaints.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. Secretary Becerra, 18 States (CA, DE, DC, GA, GU, HI, IL, MD, MA, MO, NJ, OH, PA, PR, RI, SC, TX, and VI) are facing a reduction in their TANF block grant as penalty for not meeting the Federal 90-percent paternity establishment requirement in the child support enforcement program. States had challenges meeting the requirement during COVID due to limited operations and delays for DNA testing and paternity establishment and adjudication.

Since States were unable to meet these requirements due to forces outside of their control, will the administration commit to working with us on a narrow fix that will

hold States harmless from their inability to meet the Paternity Establishment Percentage during the pandemic?

Answer. The administration is willing to work with Congress on a statutory fix that would address this penalty issue. However, HHS has also placed on its Spring 2021 Unified Agenda a regulation that will propose to modify the Paternity Establishment Percentage performance requirements in child support regulations under 45 CFR part 305 to provide relief from financial penalties to States impacted by the COVID–19 pandemic. More about the proposed rule is available here: *https://www.reginfo.gov/public/do/eoDetails?rrid=186762*.

Question. President Biden, as well as CDC officials, tout that this budget reflects the President's commitment to close health disparities and expands access to quality care for communities in need. In 2018, a bill led by myself and Senator Cory Booker, the Sickle Cell Disease and Other Heritable Blood Disorders, Research, Surveillance, Prevention, and Treatment Act of 2018 was signed into law. Over 60 percent of sickle cell patients are Medicaid recipients. In FY 2021, Congress appropriated $2 million to the CDC for this program and $7.205 million to HRSA for the Sickle Cell Disease Treatment Demonstration Program.

In this budget proposal, you only request $2 million for the CDC's Sickle Cell Data Collection program. In last year's Budget Justification, CDC Officials estimated that the agency would need $25 million to effectively operate the CDC's Sickle Cell Data Collection program. Was last year's Justification taken into account when preparing this year's budget?

Answer. CDC's Sickle Cell Data Collection (SCDC) program, has afforded CDC the knowledge and ability to align with Public Law 115–327. Comprehensive surveillance provides the necessary evidence for research, policy and practice advancements to increase access to adequate care and treatment for people with Sickle Cell Disease (SCD). Prior to FY 2021, funds from HHS, CDC and the CDC Foundation supported 11 State-based programs to participate in SCDC, covering an estimated 36 percent of the Nation's SCD population. The $2 million FY 2021 appropriations along with other one-time, one-year funds, have helped sustain CDC's program in these 11 States to collect and synthesize data and produce a complete picture of SCD in their States.

Question. What policies advanced through this budget increase access to quality care for Sickle Cell Disease patients?

Answer. The FY 2021 appropriation of $2 million in addition to other funding sources has enabled CDC to continue funding 11 State-based programs to participate in SCDC, which implements innovative data linkage to produce a modern, comprehensive, and dynamic data source for SCD surveillance. This network of State-based programs makes it possible to identify inequities in access to care and provide a science-based approach for directing policy initiatives for improving care.

SCDC program findings have enabled two State-based awardees to address access to care issues; we anticipate more reports of impact as other States develop and establish their systems.

As SCDC continues to capture data and conduct analyses, CDC looks forward to sharing impactful findings resulting from this population-based, longitudinal network of State-based surveillance for SCD. Additionally, the SCDC program is working to address health equity by using data to inform local, State, and Federal efforts to reduce health outcome and health resource disparities.

Question. What policies do you envision in relation to value-based arrangements (VBAs), new models of care, or access to innovative therapies?

Why is this not reflected in the budget?

Answer. Innovation is important to advancing goals in health care, including for those with Sickle Cell Disease. Sickle Cell Disease (SCD) affects approximately 100,000 Americans and continues to be a major cause of morbidity and mortality. Given the gravity of the disease, in 2018, HHS convened the HHS Sickle Cell Disease Workgroup to address the transition from pediatric to adult care for this population and to lead efforts to expand data collection. In September 2020, CMS issued a data highlight entitled "At a Glance: Medicaid and CHIP Beneficiaries With Sickle Cell Disease." This data brief found that in 2017, 41,995 people enrolled in Medicaid and CHIP were identified with SCD, most of whom were under age 65. CMS also released a SCD indicator in the CMS Chronic Conditions Warehouse in order to support further research. In addition, two awardees of the 2016 4-year Pediatric

Quality Measures Program (PQMP) grants are currently testing the feasibility of reporting the two sickle-cell measures developed through the PQMP at the State level. The awardees are working with five State Medicaid programs; an External Quality Review Organization; the American Academy of Pediatrics; and the Pacific Regional Sickle Cell Collaborative, made up of four western States. I look forward to expanding on this important work and keeping you informed.

Question. According to the estimates published in the 2018 Physician Fee Schedule, CMS estimated that by 2020, 50,000 beneficiaries would be enrolled annually in the Medicare Diabetes Prevention Program, at an average estimated savings of over $2,000 per person over 3 years.

As noted in CMS's first evaluation report on the program in April of 2021, only 2,200 people cumulatively have enrolled. One recognized problem, which has been flagged for you before, is that CMS only allowed in-person delivery of Diabetes Prevention Program (DPP) to Medicare beneficiaries. You also know there are no in-person DPP sites in many locations, including many areas in South Carolina, and there are no virtual locations in Alabama at all.

Senate supporters of this program have also heard CMS believes it lacks the legal authority to expand MDPP beyond in-person delivery.

Assuming that we gave you that authority right now, how fast could CMS expand the program and how much could this save the Medicare trust fund, 3 years after the proposed expansion took effect?

If CMS expanded the DPP program to include virtual and video programs, would it reach more non-white beneficiaries?

Answer. Innovation is important to advancing goals in health care, and the CMS Innovation Center is integral to the administration's efforts to promote high-value care and encourage health-care provider innovation, including virtual and digital health innovation. With respect to the Medicare Diabetes Prevention Program (MDPP) expanded model, I understand that CMS issued regulatory flexibilities in response to the COVID–19 pandemic, including waiving the limit on virtual sessions that can be provided by MDPP suppliers when in-person classes are not safe or feasible. MDPP suppliers must remain prepared to resume delivery of MDPP services in-person to start new cohorts and to serve beneficiaries who wish to return to in-person services when the flexibilities granted during the pandemic are no longer in effect.

Question. New data has just been released by the National Opinion Research Center (NORC) at the University of Chicago, finding that nearly two-thirds of assisted living facilities reported no deaths from COVID–19 in 2020. Despite this positive data, I am concerned about inequalities in the distribution of the Provider Relief Fund (PRF). Assisted living providers caring for nearly 2 million elderly individuals—the population most vulnerable to COVID—have received less than 1 percent of all provider relief funding to date.

Assisted living providers often went above and beyond by adapting to new building layouts, policies, rules, and changing reporting requirements while also working to secure scarce PPE and testing supplies. In addition, many operators increased pay, provided extra benefits, and made operational changes to staffing in order to limit exposure and possible COVID–19 spread. We now know that assisted living caregivers will suffer $30 billion in losses through June 2021 due to these efforts.

It appears the provider relief fund has a remaining balance of about $24.5 billion. We anticipate your department will be announcing an allocation shortly to help those providers who have yet to receive funding for quarters three and four of 2020, as well as quarters one and two of 2021 for expenses and revenue loss. It is critical that these funds be allocated quickly, since it was during this time period when COVID was at its worst. I am concerned that some provider groups have not received to date what I consider an equitable level of assistance for their extraordinary efforts and that is the assisted living communities.

According to the GAO, they were allocated $627 million out of the $175-billion fund. These senior living providers took on a very similar role as other care providers who served on the front lines of this pandemic such as hospitals and nursing homes, and yet they have not being treated equitably in terms of relief.

Can you assure me that these front-line assisted living operators will be allocated a meaningful level of funding in Phase 4?

Over half of assisted living facilities nation-wide are operating at a loss and many say they will not be able to sustain operations for another year if they do not receive Federal relief. How do you envision implementing an equitable PRF distribution to these assisted living providers who need immediate assistance?

Where are the latest HHS reports related to the status of assisted living centers and nursing homes?

What has occurred now that the American Rescue Plan of 2021 has been administered?

What is the take-up rate in vaccinations among this patient population?

What collaboration efforts are ongoing between CMS and other agencies?

Where are the current COVID relief dollars being directed to support this sector?

Answer. Thank you for raising this important issue. I appreciate the care being given to seniors across the Nation and recognize that some nursing homes are still experiencing financial burdens related to the pandemic.

As you know, to respond to the urgent needs of the nation's health care providers in the wake of COVID–19, Congress established the Provider Relief Fund (PRF)—an investment to stabilize the U.S. health care system facing unprecedented financial losses. In addition, Congress also appropriated an additional $8.5 billion for providers and suppliers of rural Medicare, Medicaid, and Children's Health Insurance Program (CHIP) services. HHS appreciates the support of Congress, State, and local governments; health-care providers; and countless others in this unprecedented coalition to defeat this virus.

HHS is committed to distributing PRF payments as quickly and equitably as possible while utilizing effective safeguards to protect taxpayer dollars. In order to distribute PRF funding as rapidly as possible at the beginning of the pandemic, HHS began by making automatic payments to providers who billed Medicare on a fee-for-service basis. In June 2020, HHS began making payments to Medicaid and CHIP providers, dentists, and assisted living facilities as well. In October 2020, HHS opened Phase 3 of the PRF to all eligible providers based on actual lost revenues and incurred expenses attributable to coronavirus, as well as to behavioral health providers who had not been eligible previously.

With a number of facilities being particularly susceptible to lost revenues or increased health care expenses as a result of the pandemic, HHS has obligated approximately $13 billion in PRF payments to long-term care facilities and senior housing, including assisted living facilities, custodial care facilities, nursing homes, and skilled nursing facilities. These payments cover lost revenues and increased costs to maintain safe environments for residents and staff.

To promote transparency in the PRF program, HHS also plans to release detailed information about the methodology utilized to calculate Phase 3 payments. Providers who believed their Phase 3 payment was not calculated correctly according to the methodology will be given an opportunity to request a reconsideration. All PRF Phase 3 reconsiderations are subject to the availability of funds.

HHS appreciates the care being given to communities across the nation and recognizes that, in doing so, some providers still have difficulties meeting their financial responsibilities. As HHS continues to distribute funds, your feedback informs our ability to administer the PRF in a manner that bolsters the health care system and helps providers experiencing COVID-related financial hardships during this crisis.

With regard to vaccinations, CMS is seeking comment on opportunities to require Medicare and Medicaid certified facilities to educate and offer the COVID–19 vaccine, with the goal of helping vaccine uptake. Unlike skilled nursing facilities or long-term facilities, CMS does not certify assisted living facilities. As part of CMS's commitment to protecting nursing home residents, Medicare and Medicaid certified facilities are now required to report vaccinations of residents and staff. CMS has posted resident and staff vaccination rates for Medicare and Medicaid certified facilities on the CMS COVID–19 Nursing Home Data webpage.

Question. Medicare Advantage (MA) represents a market-oriented, competitive, more affordable, and more comprehensive alternative to fee-for-service for seniors. Average monthly MA premiums declined substantially from 2010 to 2019, falling from $44 to $29. Both in South Carolina and at the national level, Medicare Advantage (MA) enrollment has increased dramatically in recent years, rising from 12 per-

cent of Medicare beneficiaries in South Carolina in 2009 to 27 percent in 2019, and from 23 percent of total beneficiaries nationally in 2009 to 34 percent in 2019.

In the FY 2022 HHS budget, you propose payment reductions for MA plans and propose using offsets similar to rules from the Obama administration. Could you please elaborate and expand on why this payment reduction would help the Medicare Advantage program?

Answer. The administration supports efforts to ensure that Medicare Advantage is serving the needs of beneficiaries with affordable and high-quality care, particularly as it continues to serve more Americans. In CY 2022, Medicare Advantage enrollment will total about 29.2 million beneficiaries, or 49.1 percent of all Medicare beneficiaries who have both Parts A and B. Between 2012 and 2021, private plan enrollment grew by 13.8 million or 102 percent, compared to growth in the overall Medicare population of 25 percent for the same period. CMS data confirm 99 percent of Medicare beneficiaries have access to at least one Medicare Advantage plan in CY 2021.

Question. Outdated coverage restrictions have long inhibited access to telehealth services for many of the nation's roughly 61 million Medicare beneficiaries. 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.

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.

With all of this information in mind, as well as the claim from this administration that their priorities reflect closing gaps to high quality care, why did you not include any telehealth priorities in the proposed budget?

Answer. Telehealth is an important tool to address health equity and improve access to health care. Health care should be accessible, no matter where you live. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to health care. I look forward to working with Congress to determine which flexibilities can be continued administratively and what may need to be done through legislation.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. As we previously discussed, rural hospitals continue facing unique challenges. Ensuring hospitals in Wyoming and the rest of rural America have the recourses they need is a high personal priority of mine.

In particular, I've heard from some hospitals in Wyoming that they are concerned they will not be able to meet the June 30th deadline to utilize funding provided by the Provider Relief Fund.

With the June 30th deadline fast approaching, can you please provide additional information about the types of flexibilities you support and when you will communicate information to providers?

Answer. Please note that PRF recipients may use payments for eligible expenses or lost revenues incurred prior to receipt of those payments (*i.e.,* pre-award costs) so long as the funds are to prevent, prepare for, and respond to coronavirus. It is the obligation (or incurred) date that determines whether the expense is an allowable cost, not the date of possession. If the purchase occurred within the period of availability, but the item was received after the period of availability, it would still be considered an allowable cost. The provider will need to maintain adequate sup-

porting documentation to show that the expense is attributable to coronavirus and was incurred within the period of availability. Providers must retain supporting documentation for 3 years.

HHS has also hosted webinars to provide technical assistance to providers. The recordings are made available online at *https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html.* We also encourage providers to contact the provider support line—HHS will now provide second tier technical assistance for providers and will communicate directly with them to walk through their questions. The number is (866) 569–3522; for TTY dial 711. Hours of operation are 7 a.m. to 10 p.m. Central Time, Monday through Friday.

Question. The administration's budget proposal includes provisions related to workforce programs. From our previous discussions, you know my passion for addressing the shortages of health care providers in rural communities.

Previously, I helped introduce both the Rural Physician Workforce Production Act and Physician Shortage GME Cap Flex Act. These are both bipartisan proposals to improve graduate medical education. This is vital for rural States, which face the greatest shortages of physicians.

Can you discuss the specific proposals in your budget related to health-care workforce development?

Answer. HHS is committed to strengthening the health workforce and connecting skilled providers with communities in need. The FY 2022 President's budget includes a number of proposals related to health-care workforce development. For example, the budget requests an increase of $47.3 million for the National Health Service Corps programs to improve access to quality primary care, dental, and behavioral health in underserved urban, rural, and tribal areas. In addition, the American Rescue Plan (ARP) Act provided approximately $330 million for Teaching Health Center Graduate Medical Education. These funds will support the expansion of the primary care physician and dental workforce in underserved communities through community-based primary care residency programs in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, psychiatry, obstetrics and gynecology, generally dentistry, pediatric dentistry, or geriatrics. Teaching health centers specifically have been shown to attract residents from rural or disadvantaged backgrounds who are more inclined to practice in underserved areas than those from urban and economically advantaged backgrounds. Most recently, using ARP Act funds, HHS established several new health workforce programs, including two programs supporting training activities that aim to reduce burnout and address mental health problems experienced by health care workers. HHS continues to develop the health care workforce in rural areas through the Primary Care Training and Enhancement: Physician Assistant Rural Training Program, among other programs. This particular program increases the number of primary care physician assistants, particularly in rural and underserved settings, and improves primary care training in order to strengthen access to and delivery of primary care services nationally.

Question. Will you work with Congress on proposals to reform Medicare's Graduate Medical Education program?

Answer. Encouraging more health professionals to work in rural hospitals and underserved areas, and the need to retain and train high-quality physicians to help address access to health care in these communities, is critically important. HHS is working hard to implement the provisions of the Consolidated Appropriations Act, 2021 that increase medical residency positions in hospitals in rural and underserved communities to address workforce shortages. In the FY 2022 Inpatient Prospective Payment System proposed rule released in April, CMS sought comments on implementation of these provisions and those comments are under review.

Question. Medicare is a vital program for seniors in Wyoming and across our Nation. As a doctor, I know the importance of protecting Medicare for our current seniors and future generations.

Right now, according to the Medicare trustees, the trust fund will run out of reserves by 2026. Under current law, this means the program will not be able to pay out full benefits. This means within 5 years seniors may not be able to get the care they need.

I am concerned the administration does not recognize the dire situation facing the Medicare trust fund.

Do you believe we must address the solvency of the Medicare trust fund before making any other substantial changes to the program?

Answer. Americans have paid for their Medicare. It has been a lifeline and continues to be for 63 million people today. This is why I want to work with you and the Congress to protect Medicare and find bipartisan solutions to extend the life of the Medicare hospital insurance trust fund. That's why the President's FY 2022 budget includes the President's American Families Plan Medicare tax reforms that would increase revenues to Medicare and extend the solvency of the trust fund by roughly 11 years. We need to get this right to make sure Medicare is strong for current and future beneficiaries.

Question. I help lead the bipartisan Comprehensive Care Caucus with Senators Rosen, Baldwin, and Fischer. We work in a bipartisan manner to improve hospice and palliative care.

We all support giving patients the option to receive the same quality care, in various settings, including in their communities and homes or wherever they may call home.

Can you discuss your priorities regarding hospice and palliative care?

Answer. Ensuring that patient choices are respected, including the ability to receive palliative/hospice care at home, is of utmost importance. At the same time, in providing palliative/hospice care at home, improving the safety and quality of care for patients is critical. Across CMS programs, the agency is working to address the significant and persistent inequities in health outcomes in the United States, including within hospice care. For example, earlier this year, CMS released a request for information to gather feedback from the hospice industry on ways to enhance work to close the health equity gap in the hospice quality reporting program. I look forward to working with you to ensure that patients receiving palliative/hospice care have access to high-quality care.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Next week, this committee will be holding our second hearing on mental health. Many members of this committee are working in a bipartisan manner to improve mental health.

Can you discuss your budgetary priorities regarding mental health?

Can you commit to working with me to expand the number of mental health professionals able to care for Medicare patients?

Answer. This administration shares your commitment to making quality mental health services available to all Americans, including our Nations' seniors. Americans are experiencing increased mental health challenges and greater barriers to receiving necessary behavioral health care. The FY 2022 budget provides $2.9 billion for SAMHSA's mental health activities, an increase of $1.1 billion over FY 2021 enacted. These investments will develop the behavioral health infrastructure, expand suicide prevention activities, support the success of 988 crisis services, address children's mental health, and increase community-based mental health programs that provide services to the nation's most vulnerable populations. I am committed to working with you on increasing access to mental health services for our Medicare beneficiaries.

Question. There is widespread agreement the advancements in telehealth during COVID–19 have been critical for patients. Congress is committed to working with you to make this a permanent part of health-care delivery.

In Wyoming, most of our providers are part of smaller hospitals and practices. We need to make sure government regulation is not making it more difficult for these providers to serve their patients.

As you work with us to ensure access to telehealth, can you commit to working to address needs of rural communities and small physician practices?

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. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to health care. Through the course of the COVID–19 pandemic, the delivery of health care through telehealth technologies greatly expanded. Telehealth technologies became an effective modality for the delivery of mental and behavioral care, especially for those seeking care in conjunction with substance use disorder. We have also seen rural patients avoid long travel times and increased risk of exposure to the coronavirus when telehealth technologies are used to provide for care and coordination using a team-based approach care that links the mental and behavioral health services to primary care. I look forward to working with Congress to determine which flexibilities can be continued administratively and what may need to be done through legislation.

QUESTIONS SUBMITTED BY HON. TODD YOUNG

Question. The Federal contractors that run the organ donation system—Organ Procurement Organizations (OPOs)—are massively failing patients across the country. I have been championing oversight and reform for OPOs for a few years now, including via an active, bipartisan investigation from Senate Finance Committee into OPOs and their oversight body, the United Network for Organ Sharing (UNOS). HHS finalized reforms in November to ensure that OPOs will finally be held accountable to objective data for the first time in 40 years, and that failing OPOs will actually lose their contracts. This is projected to save more than 7,000 lives every year as well as more than $1 billion annually to Medicare in avoided dialysis costs through increased kidney transplants.

The new regulation, however, currently does not allow HHS to decertify a failing OPO until 2026. What actions will you take to accelerate that timeline?

Answer. Thank you for your work through the years on improving oversight and reform of Organ Procurement Organizations. We share your desire to drive performance improvements in this area as quickly as possible. While decertification based on the new performance measures will not occur until 2026, the performance of each OPO will be assessed annually. Each OPO will have an opportunity to improve their performance and receive information about its performance following those improvements. By identifying the performance of OPOs annually, poor performing OPOs can appropriately change and adopt effective practices that improve their performance in donation and make more organs available for transplantation. OPOs identified as being lower performing at the final assessment period in of the agreement cycle would potentially be decertified or have their donation service area open for competition in 2026. We anticipate OPO performance will continue to improve when incentivized by more transparent and accountable measures provided under the final rule.

Question. What oversight is HHS providing over UNOS to ensure they're living up to the requirements set out in statute?

Answer. Thank you for your continued interest in organ procurement and transplantation. UNOS serves as the HRSA contractor for the Organ Procurement and Transplantation Network (OPTN). Organ Procurement Organizations (OPOs) are required by statute to be members of the OPTN, and there are numerous OPTN policies related to OPOs and their performance. Currently, HRSA provides oversight of UNOS through requirements of the Federal Acquisition Regulation (FAR) and specific performance-based language contained in its contract. HHS representatives meet weekly, or more often as needed, with the OPTN contractor to receive updates on all aspects of the OPTN contract. In addition, the OPTN contractor coordinates a separate weekly meeting between HHS and the volunteer leadership of the OPTN Membership and Professional Standards Committee, which is the OPTN committee that oversees compliance, performance, and patient safety monitoring of member organizations. Information obtained from the OPTN Membership and Professional Standards Committee and the OPTN contractor is shared with CMS per an information sharing agreement.

Question. Would you be willing to work with us on oversight of these organizations and UNOS so we can hold these organizations accountable?

Answer. Yes.

Question. I have worked with Senator Smith to improve public health preparedness by ensuring Federal agencies advance a "One Health" approach—the idea that human and animal health are linked, and that they should be studied together—to prevent and respond to disease outbreaks. The COVID–19 pandemic illustrates how we must focus our efforts on better understanding the connection between animal and human health.

Our legislation, the Advancing Emergency Preparedness Through One Health Act, would improve coordination among those studying animal and human health by requiring the Department of Health and Human Services (HHS), the Agriculture Department (USDA), and the Department of Interior (Interior) to adopt a One Health framework with other agencies.

What plans do you have in place to better coordinate with other appropriate departments or agencies to prepare for future zoonotic disease outbreaks?

Answer. In the House Appropriations Committee report that accompanied the most recent appropriations bill, the committee directed CDC to develop a national One Health framework to combat the threat of zoonotic diseases and advance emergency preparedness. The committee also directed CDC to work with the Department of Agriculture and Department of Interior to develop a One Health coordination mechanism at the Federal level to strengthen One Health collaboration related to prevention, detection, control, and response for the prioritized zoonotic diseases and related One Health work across the Federal Government.

The CDC One Health Office is coordinating with a core group of representatives from CDC, USDA, and DOI to draft a national One Health framework that describes a common vision and goals in the One Health space to prevent, detect, and respond to shared health threats at the human-animal environment interface. The draft framework will be shared with key Federal partners actively working in the human, animal, and environmental health sectors for feedback.

Additionally, CDC is collaborating with the Federal Bureau of Investigation and the United States Army Medical Research Institute of Infectious Diseases (USAMRIID) to establish two new interagency agreements that will support development, evaluation, and deployment of novel diagnostic assays for biothreat agents and emerging infectious diseases in both environmental samples and clinical specimens. Another key partner is the Department of Homeland Security which through their Countering Weapons of Mass Destruction Office have a Food, Agriculture and Veterinary Defense Program, as well as the National Biosurveillance Integration Center which monitors human, plant, animal, and food security threats across the globe. Lastly HHS is a participant in the interagency Defense Against Agroterrorism Working Group chaired by USDA and DHS.

Question. The Social Impact Partnership to Pay for Results Act (SIPPRA), bipartisan legislation I wrote and led with Senator Bennet (and which went through your old House committee, Ways and Means), was enacted in early 2018. It created a new Federal outcomes fund at the Department of Treasury, with additional coordination and supervision provided by an interagency Federal council that includes HHS. Applications were due over 2 years ago (May 2019). State and local jurisdictions across the country applied for SIPPRA funds, and after thoroughly reviewing these applications, a bipartisan commission recommended eight finalists for outcomes-based funding awards (October 2019).

Two of these projects, including one from my home State of Indiana, and an additional project in Spartanburg, SC, would fund home visiting services to improve health, education, and wellness outcomes for infants, young children, and their families.

Yet despite a statutory deadline of late November 2019 for the Federal Government to announce its first round of awards, as of this month, only one award out of the eight finalists has been announced. The Indiana project had to exit the process due to this delay. The others, including the South Carolina project, have been waiting for an answer now for over 2 years.

My understanding is the South Carolina project has now been transferred to the Health Resources and Services Administration (HRSA) within HHS, giving your department the primary lead in getting the groundbreaking outcomes-driven project out the door.

What steps will you and your team take to avoid further unnecessary delays, and ensure that this outcomes fund lives up to the full potential envisioned in the bipartisan legislation I and others worked together to enact?

Answer. As you know, Congress appropriated $100 million for the SIPPRA program to implement "Social Impact Partnership Demonstration Projects" and feasibility studies to prepare for those projects. Through the Social Impact Partnership Demonstration Projects, the Federal Government will pay for a project only if predetermined project outcomes have been met and validated by an independent evaluator. The SIPPRA program is administered by the Department of the Treasury, in partnership with OMB. The Federal Interagency Council on Social Impact Partnerships, chaired by OMB and made up of 10 Federal agencies including HHS, plays a key consultative role in the SIPPRA review and award process. The HHS representative to this Interagency Council is the Assistant Secretary for Planning and Evaluation (ASPE).

Due to existing expertise in evidence-based home visiting, HRSA participated in the review of two SIPPRA applications that proposed to use evidence-based home visiting interventions in their projects in the summer of 2019. The Interagency Council certified both projects in June 2020. At this time, Treasury and the Spartanburg, SC project team continue discussions regarding the project and no final award or transfer of project to HRSA has occurred. HHS continues to consult actively with Treasury on SIPPRA implementation.

Question. I have serious concerns about the administration's recent reversals of pro-life policies. These actions go against the principles held by most Americans—and certainly most of my constituents in Indiana.

Most recently, I have heard concerns from many of my constituents regarding the elimination of the Hyde Amendment in the President's FY 2022 budget proposal. This provision protects the many Americans opposed to abortion from being forced to pay for it using their taxpayer dollars. It's a protection that has had bipartisan agreement for decades—making its elimination now all the more alarming.

In light of the Hyde Amendment's elimination in the President's budget proposal and other recent reversals of pro-life policies, do you intend to use HHS's budget to advocate for policies that promote abortion?

Answer. The Hyde Amendment disproportionately impacts the growing number of low-income women of color who are enrolled in Medicaid, and is a barrier to expanding access to health care. That is why the President's first budget calls for Congress to remove the restriction from government spending bills.

The Department of Health and Human Services (HHS) implements the laws that Congress passes.

QUESTIONS SUBMITTED BY HON. MAGGIE HASSAN

Question. As you know, the opioid epidemic has devastated communities and families across the country. Since 2017, I have worked with my colleagues to secure funding for State Opioid Response grants, including more than $86 million for New Hampshire. This funding has enabled States to expand access to life-saving treatment and services for those struggling with substance use disorder.

But I am concerned that hard-won progress may be in jeopardy. As we discussed at the hearing, some of the hardest-hit States—including New Hampshire—are at risk of a dramatic cut in State Opioid Response grant levels under the program's current funding formula.

Does the Substance Abuse and Mental Health Services Administration (SAMHSA) have the authority to make adjustments or modifications to the funding formula currently used to determine State grant levels under the State Opioid Response grant program?

Answer. HHS, through SAMHSA, has the discretion to make certain adjustments and modifications to the funding formula currently used to determine State grant levels under the State Opioid Response grant program. I will work to ensure that our hardest-hit States can maintain and build upon the progress they've made.

Question. Does SAMHSA have the statutory authority to change the number of States that qualify for the up to 15-percent set-aside for States with the highest age-adjusted drug overdose mortality rate based on Centers for Disease Control and Prevention (CDC) data?

Answer. Yes. HHS, through SAMHSA, has the discretion to change the number of States that qualify for the up to 15-percent set-aside.

Question. Does SAMSHA have the statutory authority to ensure that the formula prevents a significant cliff in funding between States with similar drug overdose mortality rates?

Answer. There is flexibility in the statute that could allow HHS, through SAMHSA, to help avoid a significant funding cliff between States with similar mortality rates consistent with the FY 2020 L–HHS Report, which "urges the Assistant Secretary to ensure the formula avoids a significant cliff between States with similar mortality rates."

Question. Does SAMHSA have the statutory authority to prevent a funding cliff in certain States when compared to prior year allocations?

Answer. The statutory formula is based on mortality rates and national survey results related to drug use and drug-related deaths. The report language I referenced previously requests the Assistant Secretary to avoid significant cliffs between States with similar mortality rates and there is flexibility in the statute to help accomplish this.

Question. Will you ensure that the funding formula for State Opioid Response grants does not cause States to experience funding cliffs beginning in fiscal year 2022?

Answer. The report language I referenced previously requests the Assistant Secretary to avoid significant cliffs between States with similar mortality rates and there is flexibility in the statue for doing so.

QUESTIONS SUBMITTED BY HON. STEVE DAINES

Question. Your proposed budget eliminates the longstanding Hyde Amendment. This amendment prohibits funding under the Labor/HHS appropriations bill for elective abortions and health benefits coverage that includes coverage of elective abortions.

Please provide an estimate of how many abortions would receive Federal funding, and what amounts of Federal expenditures and State expenditures, respectively, would be incurred with respect to abortions as a consequence of eliminating the Hyde Amendment, as your budget proposes, for each fiscal year over 10 years.

Please disaggregate your estimates (1) by gestational age in weeks, (2) by State, and (3) by Federal program (*i.e.,* Medicaid, Medicare disability, and any other applicable programs funded under the Labor/HHS appropriations bill).

Answer. The FY 2022 President's budget carries out the President's stated position regarding the Hyde Amendment. The Department follows the current law when it comes to the use of Federal resources, including the Hyde Amendment that Congress first passed in 1976 as a part of the Department's appropriations.

Question. In *Gonzales* v. *Carhart,* 550 U.S. 124 (2007), the U.S. Supreme Court upheld the Partial-Birth Abortion Ban Act of 2003 (18 U.S.C. § 1531), the Federal ban on committing partial-birth abortions.

Do you agree with the Supreme Court's decision to uphold the Federal ban on partial-birth abortions?

Will you abide by this Supreme Court decision and enforce the Federal law banning partial-birth abortion?

Answer. As HHS Secretary, my role is to implement the law. As I have previously stated during confirmation hearings, the Department will follow all applicable laws as they relate to abortion and any other issue.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. Last March, the Drug Enforcement Agency (DEA) and the Centers for Medicare and Medicaid Service (CMS) issued key waivers allowing providers to prescribe medication-assisted treatment (MAT) and other necessary drugs via audio-only telehealth following an audio-visual visit, and to bill Medicare for audio-only telehealth services for substance use disorder. I've heard from behavioral health providers in Ohio that these waivers have both helped to maintain access to care safely at home as well as increased access to care for those that didn't otherwise have access to in-person treatment. Therefore, Senator Whitehouse and I introduced the

Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act last summer to make these key waivers permanent and increase overall access to MAT. Without action from Congress, these important waivers will expire at the end of the public health emergency, cutting off access to vital treatment at a time when the country is once again battling a surge in overdose deaths.

Will you commit to working with Congress before ending the emergency so that we can pass key legislation, like the TREATS Act?

Answer. HHS is dedicated to the equitable provision of evidence-based treatment to all patients. For those unable to attend treatment or counseling sessions in person, telemedicine—whether it be delivered via audiovisual platforms or an audio-only device—represents an opportunity to provide or to continue services. In a recent publication entitled "Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," SAMHSA evaluated telehealth delivery platforms in detail. The publication supports the use of these services, as they: allow those in recovery to attend treatment or counseling with minimal disruption to their daily activities; provide a means for those living in rural or remote areas to expediently access care; allow expansion of services beyond treatment facilities; improve the provider-client relationship through flexible scheduling; facilitate care coordination activities; maximize workforce productivity, and reduce burnout; and reduce service delivery costs by allowing remote work and care provision.

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. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to health care. I look forward to working with Congress to determine which flexibilities can be continued administratively and what may need to be done through legislation.

Question. Additionally, we've been working to get technical assistance for our bill from the DEA and SAMHSA but have been slowed down over concerns with potential diversion of MAT under our bill. Can you commit to working with us to get these concerns resolved in a timely manner?

Answer. Expanding access to treatment for individuals with opioid use disorder is a priority for the Biden-Harris administration, and I commit to working with Congress to expediently address concerns regarding potential diversion and other public safety issues.

Question. I'm excited to see the budget request include historic levels of funding to help end the opioid epidemic. I have been incredibly troubled by the once again rising trend in drug overdoses we've observed over the past year—overdose deaths have risen by 29 percent nationwide and 24 percent within Ohio. It's all the more heartbreaking because just a few years ago, we were making the first real progress in turning the tide of this epidemic in decades, with nationwide drug overdoses declining in 2018 for the first time since 1990. As such, this funding is more important than ever to end this epidemic once and for all. I recently introduced my bipartisan Comprehensive Addiction and Recovery Act (CARA) 3.0 legislation, which invests additional funding into original CARA programs that are providing evidence-based prevention, treatment, and recovery programs to combat addiction. In fiscal year 2021 alone, CARA programs are providing $782 million to communities to support these services. It is more important than ever that our communities are well-equipped to address substance use issues and so I appreciate your prioritization of this issue.

I was pleased to see a new 10-percent set-aside included in the Substance Abuse Prevention and Treatment Block Grant to direct funds to States for recovery support services, which can include recovery housing. Research on recovery support services, specifically, recovery housing, consistently finds positive outcomes that meet or exceed those of acute and medical model services. Recovery housing is an evidence-based service that addresses both social determinants of health as well as the chronic nature of substance use disorders. My CARA 3.0 legislation directs SAMHSA to develop guidelines that States can use to promote the availability of high quality, evidence-based recovery housing, as well as funding for States to implement the SAMHSA-developed guidelines and promote recovery housing as a treatment model.

Can you elaborate as to how SAMHSA plans to implement this proposed 10-percent set-aside and ensure local communities utilize this funding to expand access to high-quality recovery housing programs?

Answer. HHS is pleased and excited to have the opportunity to build upon SAMHSA's historic commitment to recovery support services, including high-quality recovery housing programs, through our current agency-wide planning and activities related to the robust implementation of the proposed new 10-percent set-aside for the Substance Abuse Prevention and Treatment Block Grant (SABG) to direct funds to States for recovery support services.

SAMHSA will be working closely with recovery support services partners, stakeholder groups, and technical assistance experts in promoting and advancing high-quality, evidence-based recovery support services, including those organizations that are at the forefront of promoting quality standards and certifications for recovery housing efforts. SAMHSA's efforts will include the comprehensive identification, support, and promotion of evidence-based research, literature, educational materials, training, and technical assistance regarding recovery support services.

Question. I'd like to thank you for your support for the Money Follows the Person program in the budget request. As you know, I've supported this program since its inception and have fought year after year to extend the program. In fact, I think its past time we make this program permanent and so I am currently working with Senator Cantwell on a bill to do just that. The lack of predictability that comes with a grant program can be tough for States in terms of planning for the future. This program works and its past time to make it permanent.

This program is a win-win—it provides better care to patients in a more comfortable setting at home and it saves money. Since its inception in 2007, the program has transition over 100,000 individuals from an institutional setting to the community. Furthermore, according to a 2017 Report to Congress from HHS, average per-beneficiary per-month costs decreased from $13,469 per month to $9,456 per month when beneficiaries used the MFP program to transition into home and community-based care. The report also found that the program has succeeded in lowering hospital readmission rates among those beneficiaries that transition out of nursing home care.

While all of these findings are compelling in terms of the benefits of the MFP program, one of our longstanding challenges in working on this program from a legislative standpoint is that the Congressional Budget Office is skeptical of the cost savings I just outlined.

Will you work with CBO to come up with a more realistic cost assessment of expanding this program?

Answer. Thank you for your leadership on this important issue. The Money Follows the Person (MFP) demonstration gives beneficiaries more options for their care and allows them to choose to receive care in the community, rather than institutions. This demonstration has shown promising results, including improving participant quality of life and lowering the cost of care. The administration supports a permanent extension of MFP.

Question. We all saw the conditions at the convention centers and other facilities used during the surge of migrants across the border.

What is the Biden administration doing to create better medium-term solutions for the next surge?

Answer. The HHS Office of Refugee Resettlement (ORR) is utilizing all available options to safely care for unaccompanied children, including short-, medium-, and long-term solutions. In the short term, ORR is working to ensure unaccompanied children do not spend more time in border patrol facilities than necessary by: (1) safely increasing capacity in its State-licensed network; (2) safely reducing the time it takes to place unaccompanied children with their vetted sponsors; (3) expanding influx care facilities that can meet the same standards of care used in ORR's State-licensed network; and (4) utilizing temporary Emergency Intake Sites that provide safe and appropriate care for children when necessary, for short-term placements.

Over the medium to long term, ORR will continue to build back its licensed capacity network through different avenues, working with existing and new providers. ORR is also exploring a flexible bed capacity model that will allow beds that are deactivated and held on reserve during periods of low occupancy to be quickly reactivated during surges of unaccompanied minors at the border.

Question. Recent data from the Centers for Disease Control and Prevention (CDC) indicate that drug overdose deaths skyrocketed during the COVID–19 crisis, demonstrating both the tremendous toll of this epidemic within the pandemic and the

importance of access to effective opioid treatment services. Successful treatment relies in part on clinical urine drug testing, an unbiased laboratory test, which is used in identification of addiction, diagnosis, treatment, and recovery. In particular, definitive urine drug testing provides the sensitivity and specificity necessary to enhance substance use disorder (SUD) treatment. In 2019, the Centers for Medicare and Medicaid Services (CMS) finalized regulations that included definitive drug testing in the new bundled payment for opioid treatment services. While the goal of this policy is to expand access to treatment services, this fixed payment method actually has prompted many treatment providers to forgo drug testing. Providers rely on these timely, accurate, and clinically actionable information and without the ability to utilize impartial testing many patients do not have access to successful treatment options.

Can you please speak to the importance of definitive urine drug testing in SUD treatment and explain how your department will support access to these services?

Answer. Urine drug screening is an important tool for SUD treatment, as it speaks to the patient's treatment progress. However, it is only one aspect of treatment and patient engagement for treatment. It is also important to note that the majority of Opioid Treatment Programs (OTP), housed in SAMHSA, undertake drug screening. Drug screens are fast, inexpensive and provide timely information for patient progress under their treatment program.

How is HHS encouraging providers to utilize a neutral based testing solution to ensure both Medicare and Medicaid beneficiaries have access to treatments, as well as receiving real-time reported data to help combat this epidemic?

Answer. Thank you for bringing this issue to my attention. Under SAMHSA certification standards, opioid treatment programs (OTPs) are required to provide adequate testing or analysis for drugs of abuse, including at least eight random drug use tests per year, per patient in maintenance treatment in accordance with generally accepted clinical practice. These drug use tests are used for diagnosing, monitoring and evaluating progress in treatment. Medicare began covering opioid use disorder treatment services furnished by OTPs on January 1, 2020. As required by law, OTPs are paid a bundled payment for opioid use disorder treatment services including toxicology testing. To determine this weekly bundled payment, CMS included pricing for both presumptive and definitive testing. CMS is monitoring beneficiaries' access to medically necessary definitive testing under the bundled payment for opioid use disorder treatment services. If CMS finds there are any issues with beneficiary access, CMS may consider making changes to how these tests are paid.

Regarding Medicaid, States work directly with providers, including those delivering needed SUD services to Medicaid beneficiaries. There also are various Federal authorities and CMS-led initiatives available to assist States in their ongoing efforts to respond to the opioid crisis. For example, in November 2017, CMS announced a new opportunity under the authority of section 1115(a) of the Social Security Act for States to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with substance use disorders including opioid use disorder, as well address particular challenges raised by the opioid epidemic in their State. In addition, CMS created similar flexibility to test more comprehensive approaches to care for beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED). To date, 27 States and the District of Columbia have an ongoing SUD and/or SMI/SED section 1115(a) demonstration.

QUESTIONS SUBMITTED BY HON. MARK R. WARNER

Question. One issue that has significantly impacted Virginia and that I have been working to address is the significant increase of black lung in our coal miners. Black lung disease is a debilitating, potentially fatal disease caused by long-term exposure to coal dust.

If black lung is caught early, steps can be taken to help prevent it from progressing to the most serious forms of the disease. Currently, the Centers for Disease Control's National Institute of Occupational Safety and Health offers free health screenings to miners and the accessibility and confidentiality of these screenings enable miners to get early screening for the disease.

Unfortunately, there are only two NIOSH Mobile Testing Units in the Appalachian region. One of these units is not currently operating and one unit is expected to be defunct within a couple of years.

This year, I am requesting that the Senate Appropriations Committee provide at least $2 million to NIOSH for a new mobile screening unit and to better maintain existing units. I am hopeful this request will be granted, but will you also commit to working with me to ensure that these units remain functional?

Answer. HHS and CDC are strongly committed to maintaining mobile outreach services to bring respiratory health screening to coal miners. The Coal Workers' Health Surveillance Program (CWHSP), operated by CDC, provides respiratory health screening to coal miners in part through mobile outreach. Mobile outreach has played an important role in bringing screening consistent with requirements of the Federal Mine Safety and Health Act and Federal regulations at 42 CFR part 37 to geographical areas with low participation rates and areas at high risk for Black Lung. Free, convenient, confidential mobile health screening provided by CDC has proven itself as a way to markedly increase miners' participation in CWHSP.

Question. Could we also work together on additional efforts to address the increased incidence of black lung in coal miners?

Answer. The President's FY 2022 budget requests an additional appropriation of $690,000 for the Black Lung Clinics Program (BLCP). The additional appropriation will be distributed proportionally to 15 Black Lung Clinic Program grantees and will allow the clinics to continue to provide high quality medical, outreach, educational, and benefits counseling services to current, former, retired, and disabled U.S. coal miners. COVID–19 has impacted these clinics, requiring additional safety and cleaning protocols to reduce the risk of transmission, to include the ability to purchase the necessary equipment related to these protocols such rapid testing equipment, installation of negative pressure rooms, UV lights and exhaust fans, PPE, and sanitizing and disinfecting products to continue to screen, diagnose, and treat coal miners in their facilities. I welcome the opportunity to work with you to address this important issue for these workers.

HRSA's BLCP and CDC's National Institute for Occupational Safety and Health (NIOSH) continue to work with the U.S. Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP) to align data measures, enhance BLCP-funded clinics' ability to collect and report patient-level data to HRSA, and improve HRSA's ability to monitor and assess the burden of Progressive Massive Fibrosis.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. I was glad to see that HHS/FDA included the over-the-counter (OTC) hearing aid proposed rule on its Spring 2021 unified agenda. However, the FDA was supposed to put out a proposed rule no later than August 2020—meaning the rule is over 8 months late.

Please provide a detailed timeline on when this proposed rule will be released for public comment. Will you commit to making the release of this rule a priority?

Answer. Thank you for your leadership on this important issue. As you know, section 709 of the FDA Reauthorization Act of 2017 provides certain rule-making process requirements to establish a category of OTC hearing aids. Consistent with FDARA, FDA is a developing a proposed rule which is a priority for the Department. The regulatory process includes reviews at multiple levels of government. We believe that facilitating access to hearing aids, while also ensuring patients can depend on these products, is important. Establishing a category of OTC hearing aids will help serve these interests by lessening regulatory burdens and removing barriers for patients to have access to these devices, while also ensuring that they are safe and effective.

Question. During your confirmation process, I submitted a question for a record asking whether, as HHS Secretary, you would "commit to conducting a review of the Department's preexisting executive authorities to determine how they can be used to lower the prices of critical drugs . . . that millions of Americans rely on." In your response, you said you would "conduct a thorough review to identify and analyze the tools at our disposal to reduce the price of drugs and make treatments more affordable for the American people." Please provide an update on this review.

What steps have you taken to analyze HHS's tools?

Which tools have you identified?

What analyses have you conducted on compulsory licensing and march-in rights?

How is HHS planning on using these authorities to lower drug prices, and which drugs is HHS considering targeting?

Answer. Making treatments more affordable for the American people is a top priority of the administration. We are committed to doing a thorough review to identify and analyze the tools available to HHS to reduce the price of prescription drugs. The President supports reforms that would bring down prescription drug prices, and our review of authorities available to HHS is underway.

NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. Essential to this mission is ensuring a continued high return on public investment in research. There are numerous policies and regulations surrounding the transfer of NIH technology to a company for commercial development.

The Bayh-Dole Act was designed to address the absence of incentives to commercialize government-funded inventions by allowing small businesses or nonprofit organizations, such as universities, to claim title to inventions generated during performance of a Federal grant or contract. The Federal Government may grant a license to use the intellectual property arising from government funding without the permission of the rights-holder under certain circumstances, including when "action is necessary to alleviate health and safety needs which are not reasonably satisfied" or when the benefits of the patented product are not "available to the public on reasonable terms."

HHS, NIH, and other agencies have been petitioned to take action under these provisions, and HHS will continue to give such petitions due considerations.[1] HHS will also engage other government agencies to address barriers to accessing government-funded inventions. The statute provides clear constraints to these authorities, and HHS will continue to explore opportunities to use these and other authorities in ways that can lower the prices of medical products.

Question. Does the CDC plan to extend the Federal eviction moratorium?

Answer. The CDC eviction moratorium took effect September 4, 2020 and was initially slated to extend through December 31, 2020. However, it was extended legislatively through January 31, 2021, and extended again by CDC through March 31, 2021. On March 29, 2021, CDC further extended the moratorium until June 30, 2021.

Question. In releasing updated guidance on mask-wearing in May 2021, did the CDC consult with the Department of Labor, OSHA, labor groups, or any workplace safety experts?

Is the CDC considering providing updated guidance with a focus on the threat of workplace exposure, that addresses issues such as mitigation measures needed to protect workers in workplaces where large numbers of both vaccinated and unvaccinated people work in enclosed spaces, and in workplaces where workers come into frequent contact with coworkers or members of the public who are both vaccinated and unvaccinated?

Answer. CDC is continuing to update guidance documents based on the best available science and based on the trajectory of the pandemic in the United States. CDC is also working to make them applicable to multiple settings and scenarios. This will make it more efficient to search and find relevant public health guidance.

The Occupational Safety and Health Administration (OSHA) updated its guidance on mitigating and preventing the spread of COVID–19 in the workplace in June 2021, and it remains a resource for businesses. CDC and HHS assisted OSHA's development and review of the updated information for business, employers, and workers that provides guidance for all industries (excluding health care and certain other settings), including information on vaccinations in the workplace and how varying vaccination status among workers influences workplace control measures.

CDC has specific guidance for health-care settings which includes comprehensive recommendations for protecting health-care personnel, patients, residents, and visitors in a health-care setting from SARS–CoV–2 transmission. CDC's health-care

[1] Another provision, 28 U.S.C. § 1498, allows the Federal Government to "use or manufacture" technologies protected under current U.S. patents, while giving the patent owner "recovery of his reasonable and entire compensation for such use and manufacture"; *https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title28-section1498&num=0&edition=prelim.*

guidance also includes information on modifications to existing infection control guidance that might be implemented based on vaccination status. This guidance has been updated regularly to reflect new information on the epidemiology of current infections and the science underlying our understanding of transmission.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

Question. This year's budget includes the largest increase for CDC in almost 20 years. A funding increase on its own won't be enough to achieve necessary structural and cultural reforms for the agency.

What are you and CDC leadership doing to encourage cultural shifts that help the American people trust CDC leaders, data, and guidance today and in the face of future threats?

Answer. HHS and CDC are working to ensure that public health decisions are based on the highest-quality scientific information. Looking to the future, I want to work within the administration and with you to address longstanding vulnerabilities in our core public health infrastructure, including data, workforce, laboratory, domestic preparedness, and global health security. We must work together over the months and years ahead to reinforce the foundations, partnerships, modernizations, and innovations that we have initiated during this pandemic—ensuring robust public health systems continue to be grounded in science.

Question. Public-private partnerships have been the key to our success in combating COVID–19. Leaders within our government agencies should hear from innovators with novel technologies to understand what is available to address some of our most challenging and complex issues, especially in health care.

Is there any official policy preventing these types of meetings between industry leaders and the heads of your non-regulatory public health agencies?

Do you think it would be beneficial for principals of HHS agencies to have the same opportunity to meet with these companies?

Answer. We will continue to partner with other Federal agencies, States, and the private sector to execute a whole-of-America response to this pandemic in accordance with current applicable Federal laws and departmental and agency policies.

Question. The FDA user fee programs are critical to ensuring that patients have access to medical products. These programs supplement FDA's congressionally appropriated resources to keep pace with science and bring cutting-edge medical treatments to patients who need them.

FDA's growing reliance on industry user fees results in less accountability to Congress, and therefore, American patients and families. How does your budget ensure that FDA is accountable to patients and taxpayers?

Answer. I believe that FDA's user fee programs offer a strong example of what can be achieved when Congress, FDA, industry, and other stakeholders work together towards the same goal. The user fee programs have allowed FDA to speed the application review process without compromising the agency's high standards. The user fees provide a critical way to ensure that FDA has the resources needed to conduct reviews in a timely fashion.

Question. The budget proposal includes an increase of $37.5 million (for a total of $347.6 million) for infrastructure, buildings, and facilities at the FDA; $19.5 million for infrastructure, with $2.5 million for White Oak; and $18 million for buildings and facilities.

What will the $2.5 million for White Oak be spent on?

What will the $18 million for buildings and facilities go towards?

What proposed resources are included for activities like the purchase of furniture, scientific equipment, or other materials and supplies?

Answer. Funding for Infrastructure—GSA Rent, Other Rent and Rent-Related (OR&RR), and White Oak Consolidation—and Buildings and Facilities (B&F) provides the facilities, infrastructure, and utilities required by FDA's workforce to carry out its public health mission, respond to food safety and medical product emergencies, and protect and promote the safety and health of American families. FDA facilities directly support its strategic priorities by ensuring FDA staff have the modern infrastructure and labs across the country to execute the agency's vital pub-

lic health mission. It is important that these facilities provide safe, suitable and reliable work environments and to support changing scientific and regulatory requirements and technology.

Question. Two of the COVID–19 vaccines use a messenger RNA (mRNA)-based platform.

What resources in your budget are dedicated to improve the ability for FDA to more efficiently review products that incorporate platform technologies?

Answer. FDA undertakes preparations to respond to a wide variety of natural and human-caused threats and public health emergencies (*e.g.,* COVID–19) that involve, affect, or require the use of FDA-regulated products to help keep the public safe. FDA carries out many activities to protect and promote public health to prevent a public health emergency, and, when one occurs, during a public health emergency. Specifically, the President's FY 2022 budget includes $153,113,000 for bioterrorism/medical countermeasures and $39,591,000 for pandemic influenza.

FDA centers are committed to promoting development of innovative products, including platform technologies. Throughout the pandemic the agency has utilized significant resources towards meetings, guidance, review, and surveillance of innovative products to treat and prevent COVID–19. Specifically, we have dedicated significant resources to the review and monitoring of mRNA products and other COVID–19 vaccines.

Question. During your confirmation process you indicated that you share my goal of ensuring FDA and CMS are working more closely together. The FDA's recent approval of a first-of-its-kind treatment for Alzheimer's disease will put your words to the test.

Currently, Medicare won't provide coverage of the diagnostic imaging necessary to determine whether a patient is a candidate for this new treatment. How CMS approaches coverage of the treatment and diagnostic is of critical importance for Alzheimer's patients and caregivers.

What investments does the budget include to modernize CMS processes to ensure more timely access to novel medical products?

I recently sent you a letter requesting that CMS reassess its current policies and provide coverage of the necessary screening test to remove barriers for patients accessing an approved treatment for Alzheimer's disease. When can I expect a response to my request?

Answer. The FDA has approved Aduhelm for the treatment of Alzheimer's disease and Medicare beneficiaries can begin receiving this drug today as long as its use is reasonable and necessary under the Medicare statute. Medicare Administrative Contractors make claim-by-claim determinations regarding whether items or services are reasonable and necessary. If a provider has questions about coverage of Aduhelm, they should contact their local Medicare Administrative Contractor for more information. It is my goal to respond to letters timely and I will check in with my staff on the status of your letter.

Question. CMS recently announced that it would be reviewing an approved 1332 waiver granted to the State of Georgia. The administration cited changes in Federal law and administrative policies as the reason for reviewing the already approved waiver. These Federal policy changes apply to many States, however, not just Georgia.

Is the Department planning to review other approved 1332 waivers in response to these shifts in Federal policy? If so, which States?

Answer. The Department of Health and Human Services and the Department of the Treasury are reviewing all section 1332 waivers in light of recent changes in Federal law and policies, including the enactment of the American Rescue Plan Act of 2021 and the adoption of Executive Order 13985 and Executive Order 14009. This administration is committed to protecting and expanding Americans' access to quality, affordable health care and making the health-care system easier to navigate. Through section 1332 waivers, the Department aims to assist States with developing health insurance markets that expand coverage, lower costs, and ensure that health care truly is a right for all Americans.

Question. A number of Medicare and Medicaid policies are currently slated to remain in effect until the public health emergency ends. As such, your budget model must assume an end date of the emergency to accurately forecast spending.

When does the President's budget assume the emergency will end?

Answer. The PHE is assumed to continue at least through the 2021 calendar year in the FY 2022 President's budget baseline. The actual timing will depend on progress against the pandemic. The Families First Coronavirus Response Act (Pub. L. 116–127) provides a temporary additional 6.2 percentage points to the Federal Medical Assistance Percentage (FMAP) during the PHE and it expires at the end of the quarter in which the PHE ends.

Question. Cyberattacks against the health-care sector have dramatically increased over the past several years, spiking since the onset of the COVID–19 pandemic.

What does your budget do to defend our health-care sector and coordinate prevention and response efforts among the public and private health sectors?

Answer. HHS plays a significant role in enhancing and protecting the health and well-being of all Americans by preparing for and responding to cybersecurity threats. This budget supports the operations of the following HHS entities that are responsible cybersecurity assistance to the health care and public health (HPH) sector:

The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) Critical Infrastructure Protection Division is the sector risk management agency. It promotes resilience in the sector to manage risk and coordinate an effective response to new cybersecurity threats.

The Office of Information Security Cybersecurity Governance Risk and Compliance Division supports the department's role as sector risk management agency by coordinating efforts to improve the cybersecurity of the sector with public and private industry partners. The division manages and implements the requirements of section 405(d) of the Cybersecurity Act of 2015, which directs HHS to improve cybersecurity in the health-care industry by taking actions towards aligning health-care industry security approaches.

The Health Sector Cybersecurity Coordination Center (HC3) enables improved cybersecurity information sharing between HHS, its Federal partners, and the HPH sector. HC3 collaborates with the HPH sector to understand cyber threats, learn adversaries' patterns and trends, and provide information and approaches on how the sector can better defend itself.

Question. How is HHS coordinating with other Federal agencies in their cybersecurity response and prevention?

Answer. As required by the Pandemic and All-Hazards and Advancing Innovation Act of 2019, ASPR led the development of a "strategy for public health preparedness and response to address cybersecurity threats." This strategy is in final clearance within the Department and is anticipated to be delivered to Congress soon. Confronting cybersecurity threats requires contributions from across the Federal Government, including the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency, the Federal Bureau of Investigation's National Cyber Investigative Joint Task Force, and other Federal Government organizations such as the National Cybersecurity Center of Excellence (NCCoE), as well as from other stakeholders, to include States and the private sector with expertise or authorities relevant to the cybersecurity and resiliency of the health sector. This strategy identifies duties, functions, preparedness, and response goals for which HHS is responsible for the Healthcare and Public Health (HPH) Sector. It also includes strategies to address identified gaps and strengthen public health emergency preparedness and response capabilities.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. More than 4 million Texans, including half of all children in the State, depend on the stability of the State's Medicaid program for themselves and their families. Over 50 percent of inpatient days in our children's hospitals are paid for by Medicaid, and vital mental health providers like Certified Community Behavioral Health Clinics rely on funding through Medicaid and our 1115 waiver.

In April, the Biden administration rescinded approval of Texas's 1115 waiver extension. This unprecedented action by CMS threatens the security of the State's Medicaid program, disrespects the continuity of this agreement, and erodes the partnership between the State and CMS. While our current waiver runs through Sep-

tember 2022, the extension addressed a funding cliff that puts at risk access to vital services for our most vulnerable.

The last time you came before this committee there was a discussion about waivers and you committed to working with States in their efforts to provide care for these vulnerable populations. It is my understanding from CMS that the decision to review the waiver agreement was made in February and neither Texas nor the congressional delegation was informed of this until the waiver was rescinded.

Given your desire to work with States on these efforts, why was Texas not informed that a review which ultimately led to the waiver being rescinded was happening?

Is this the type of engagement we should expect from the administration moving forward?

Can you commit to providing Texas with a fair and expeditious review of a subsequent waiver application?

Answer. The partnership between States and the Federal Government is central to Medicaid, and this administration is committed to working with States to strengthen this vital program. HHS is committed to supporting State innovation and States' ability to test different models that meet the unique needs of their residents and to ensure open, and timely communication with our State partners. Medicaid is an important lifeline for many American families. It is important that States' Medicaid section 1115 demonstrations promote the objectives of the Medicaid program and comply with the requirements of section 1115 and its implementing regulations.

I agree that States need certainty and predictability from the Federal Government, and it's important that HHS works closely with States to help them explore ways to address the unique needs of their residents. We look forward to continuing to work with Texas.

Question. I'd like to ask you about your budget request of $3.3 billion for the unaccompanied children program. Among its other responsibilities, HHS is responsible for ensuring the well-being of unaccompanied migrant children who are placed with sponsors.

I believe that we need to invest more resources in vetting these sponsors and following up with the children who are placed with them. A couple years ago, the HSGAC Permanent Subcommittee on Investigations released a report that found that a number of children placed with sponsors were forced to work on an egg farm in Ohio in 2015.

The subcommittee also uncovered a number of other instances of abuse, including children were withdrawn from school and forced to work long hours, and a sponsor who beat a child with an electrical cord.

In the case of the child who was beaten with an electrical cord, the subcommittee concluded that HHS should have conducted a home study before placing the child, but did not do so. Furthermore, in the first 3 months of this fiscal year, HHS has been unable to reach approximately 20 percent of the children who are placed with sponsors 30 days after release.

Can you commit to using the funds requested for the unaccompanied children program to enhance vetting of sponsors and services to ensure that children are safe after they are placed with those sponsors?

Answer. Yes, the budget request includes expanding the scope of post-release services and the number of children who receive them. The budget request will also support the ongoing implementation of other critical programmatic reforms, such as improved case management that reduces the time it takes to safely unify children with their vetted sponsors.

Question. The mental health and welfare of American citizens is foremost on my mind these days. The United States spends enormous sums of money each year to make services available to Americans struggling with a mental or behavioral health medical condition. However, COVID–19 has laid bare an uncomfortable truth for policymakers—how we plan for and spend these funds isn't working as well as it could.

There are unmet needs and other problems without our local health systems that we need to begin solving for this year. For instance, our medical workforces are unable to meet all of the crisis care needs that exist in our communities today. The

expected success of the 988 crisis hotlines when they are up and running shortly will increase service requests even more. These issues are immediate and work should be undertaken to address them immediately.

However, this committee should not stop there.

I will be working with a bipartisan group of Senators to develop a vision for reimagined systems of mental and behavioral health in communities all across America. A legislative and regulatory initiative that correctly considers mental well-being to be a basic and foundational aspect of American society throughout all stages of life—from birth to death. A modern system with a workforce capable of managing the needs of its communities. A system designed to not only improve the health-care response but also provide access to other important resources like early and continued education. A Federal approach to community support that properly balances the needs of local communities with the national interests of the Federal Government.

We would like to work with you. This is a non-partisan problem in need of bold solutions, and I believe the administration's support and collaboration of our efforts could be extremely important for our future success. Will you work with us, Mr. Secretary?

Answer. I commend your emphasis on the need for systems improvement to address the behavioral health needs in America's communities, particularly in the aftermath of COVID–19. HHS is in agreement that mental well-being is a critical element in the health of the country and that a number of factors which negatively impact health and well-being need to be addressed simultaneously, including access to quality care, building and sustaining a sufficient workforce and addressing social determinants which intersect with health burden. SAMHSA's implementation of the 988 suicide prevention and mental health crisis hotline presents unique opportunities to transform the system of care so that individuals receive help where and when they need it so that adverse outcomes are minimized. I look forward to ongoing partnership to realize the potential of this transformative moment.

Question. Along with Senator Bennet, I have introduced S. 1427, the Increasing Access to Biosimilars Act. This proposal, which was introduced in both the House and Senate, would implement a shared savings program where Medicare savings associated with prescribing a biosimilar would be shared with providers and more importantly patients through reduced co-pays. We have previously spoken about the potential of a shared savings approach to help reduce the cost of prescription drugs and boost biosimilar uptake.

Is this something the administration has discussed through CMMI or other avenues available?

If not, are you looking at other ways to incentivize the uptake of lower-cost biosimilars?

Answer. Prescription drug costs are too high for American patients and families. From the meetings I have had with Senators, 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 and biosimilars certainly have a role to play in creating competition for reference products. I look forward to working with you and others in Congress to lower the cost of prescription drugs.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. The Grassley-Warren Over-the-Counter (OTC) Hearing Aid Act was signed into law in 2017 and required the Food and Drug Administration (FDA) to issue draft rules by August 2020, but the agency failed to do so. In November 2020, I sent a letter along with Senator Warren to the FDA urging them to initiate overdue rulemaking. To date, the FDA has taken no action. They have communicated the draft regulations are under legal review. On June 9, 2021, Secretary Becerra stated, "I know that we are in the works. I asked about this myself." At a House Energy and Commerce Committee hearing on May 12, 2021, he made similar comments, stating, "It is still undergoing review."

Given Secretary Becerra has been asked similar questions from Congress over a 5-week period and had another week to provide an answer I am asking again, what is the timeline for the FDA to issue the over-the-counter hearing aids regulations?

If a timeline is not set or cannot be provided, what agency and office in the executive branch is currently reviewing the draft regulations?

Answer. Thank you for your leadership on this important issue. As you know, section 709 of the FDA Reauthorization Act of 2017 provides certain rulemaking process requirements to establish a category of OTC hearing aids. Consistent with FDARA, FDA is a developing a proposed rule which is a priority for the Department. The regulatory process includes reviews at multiple levels of government. We believe that facilitating access to hearing aids, while also ensuring patients can depend on these products, is important. Establishing a category of OTC hearing aids will help serve these interests by lessening regulatory burdens and removing barriers for patients to have access to these devices, while also ensuring that they are safe and effective.

Question. At the June 10, 2021 hearing, I asked you this question but you failed to directly respond. On March 8, 2021, I wrote to the Department of Health and Human Services (HHS) and asked several questions relating to the origins of the coronavirus. I also asked about what, if any, oversight was done on the coronavirus grants sent by Dr. Fauci's unit within the National Institutes of Health to EcoHealth Alliance which issued sub-grants to the Wuhan Institute of Virology. According to reports, $600,000 to $826,000 was sent to the Wuhan Institute of Virology by EcoHealth Alliance to study bat coronaviruses. On May 21, 2021, the Department of Health and Human Services responded to my letter but failed to answer whether any oversight was done. On May 26, 2021, I wrote a follow-up letter to the Department of Health and Human Services asking again what, if any, oversight was done. I have not received a response yet, as of July 16, 2021.

Did the Department of Health and Human Services, specifically Dr. Fauci's unit, do any oversight of the taxpayer money sent to the Wuhan Institute of Virology?

If so, can you say with certainty that the money wasn't misused by the Chinese government, including with gain-of-function research?

If no oversight was done, please explain why that's the case.

Answer. The application from EcoHealth Alliance was subjected to NIH's two-stage review process in which both scientific review (*i.e.,* rigorous peer review) and NIH review (Advisory Council review) occurred. Once awarded, adherence to the NIH Grants Policy Statement became a term and condition for funds to be disbursed and mechanisms for monitoring awards are detailed in Chapter 8.4 of the NIH Grants Policy Statement.[2] Notably, the application submitted to NIH by EcoHealth Alliance, did not propose research to enhance any coronavirus to be more transmissible or virulent in the human population and NIH would not have approved this research. The results of the approved proposal and funded Wuhan Institute of Virology experiments were published contemporaneously in peer-reviewed scientific literature to inform the global scientific community of its findings in accordance with NIH policies.

Question. In July 2020, as chairman of the Senate Finance Committee, I held two hearings to discuss how the United States can protect the reliability of our country's medical supply chain during COVID–19. This hearing convened U.S. government officials and a panel of industry experts to discuss the difficulties we faced securing PPE and other critical medical supplies during the pandemic. (Many of these goods are made abroad, in foreign countries like China.) On June 8, 2021, the Biden administration announced its plan to convene a task force to address short-term supply chain issues. The plan focuses on four critical products: semiconductor manufacturing, large capacity batteries, like those for electric vehicles, critical minerals and materials, and pharmaceuticals and active pharmaceutical ingredients (API). However, this plan does not take into account supply chain issues related to PPE and other medical equipment—items that hospitals and other health care providers found impossible to source at the beginning of the pandemic. This pandemic has made it abundantly clear that we as a Nation can no longer count on other countries, like China, to be the sole source of our medical supplies.

How does HHS plan to address supply chain vulnerabilities for PPE and other medical supplies?

Does HHS have plans to work with its private sector partners to onshore certain essential medical supplies and, if so, what supplies is HHS targeting? If not, why not?

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[2] *https://grants.nih.gov/grants/policy/nihgps/nihgps.pdf.*

Answer. The global pandemic has highlighted the vulnerabilities of the global supply chain. It is critical that steps are taken to invest in expansion of U.S. domestic manufacturing capacity. To that end, the Office of the Assistant Secretary for Preparedness and Response (ASPR) is leveraging the authorities delegated to the Secretary under the Defense Production Act (DPA) to ensure that private-sector partners making life-saving products are able to acquire raw materials, retool their machinery, scale their production facilities, train their workforces, and ultimately deliver their product. Throughout the COVID–19 response, ASPR has used the DPA authority to issue 46 priority ratings for United States Government (USG) contracts for health resources, eight priority ratings for USG contracts for industrial expansion, 3 priority ratings for non-USG contracts to indirectly support COVID–19 and/or mitigate the potential stockout of critical lifesaving therapies. Going forward, ASPR will continue to build capacity and partnerships with private industry toward the shared goal of ending the COVID–19 pandemic.

ASPR is also working to support efforts in expanding the domestic industrial base. These industrial base expansion (IBx) efforts seek to reduce supply chain vulnerabilities and generate a domestic "warm-base" for manufacturing that can be leveraged in a crisis. Consistent with the shift towards onshoring essential medical supplies, since the Spring of 2020, all 12 SNS contracts, worth approximately $380 million, for N95 respirators were for products manufactured in the U.S. Furthermore, with $10 billion received for industrial base expansion, ASPR has been establishing and maintaining domestic capacity for critical supplies. ASPR has invested funding to support PPE production; active pharmaceutical ingredient manufacturing capacity; additional COVID–19 testing supplies, to include swabs, tests, kits, and supplies such as reagents and resins; and raw materials to support vaccine industrial base expansion for raw materials, consumables, fill/finish capacity, needles, vials, and syringes.

Lastly, ASPR's Hospital Preparedness Program (HPP) included two requirements in the FY 2019–2023 funding opportunity announcement to help address supply chain vulnerabilities. First, HPP recipients and their health care coalitions must conduct a supply chain integrity assessment to evaluate equipment and supplies that will be in demand during emergencies and develop mitigation strategies to address potential shortfalls. Second, each health care coalition must update and maintain a regional resource inventory assessment.

Question. How is HHS working with its private-sector partners to ensure that corporations have stockpiles of select medical equipment to ensure resiliency in the future?

Answer. ASPR's Hospital Preparedness Program (HPP) supports collaboration with private sector partners for broader health care resiliency and readiness through its investment in health-care coalitions (HCCs), which are groups of individual health care and response organizations in a defined geographic location that play a critical role in developing health-care delivery system preparedness and response capabilities. HCC members actively contribute to strategic planning, operational planning and response, information-sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained health-care personnel.

Question. On May 6, 2021, Senator Wyden and I wrote to Department of Health and Human Services (HHS) in order to raise concerns related to your joint investigation of HHS Office of Refugee Resettlement's (ORR) unaccompanied alien children (UAC) program. In our letter, we asked about recent instances of abuse and about the steps HHS is taking to ensure that volunteers are properly trained and educated about the history of safety hazards and child abuse at UAC facilities. The response was due on May 20, 2021. On May 18, 2021, I led a group of Senators in writing another letter to HHS asking for details about HHS's effort to address personnel shortages at border facilities by recruiting volunteers from other parts of the Federal Government, including agencies such as NASA and the USDA. Our letter asked questions about the nature, extent, and cost of the volunteer program. The response to that letter was due on June 1, 2021. I have not received a response to either letter.

When can my colleagues and I expect responses to our letters?

Answer. Thank you for your continued interest in the Unaccompanied Children program. The Department is working to respond to your letters and will have a re-

sponse to you very shortly. I take congressional inquiries and letters very seriously and hope moving forward the Department is able to provide you with a more timely response.

According to the USA Jobs website, ORR's request for detailees from outside agencies to assist at border facilities closed on May 21st. Is it accurate that HHS is no longer seeking volunteers?

Answer. HHS continues to deploy Federal detailees who previously applied through the detail solicitation process. While HHS is not currently recruiting additional new detailees, HHS is still actively deploying detailees who previously applied to EIS locations, to ORR headquarters operations in Washington, DC, and for virtual assignments in support of the UC mission.

Question. In total, how many Federal employees from outside of HHS have received detail assignments to assist at border facilities? Which agencies are they from?

Answer. As of June 10, 2021, a total of 2,263 Federal employees were deployed to assist the Unaccompanied Children program, either in-person or virtually. Please see the table below for a complete list of Federal detailees' home agencies.

Department	Number of Federal Personnel Deployed on 6/10/2021	Total Number of Federal Personnel Deployed From 3/1/21 to 6/10/2021
ARMED FORCES RETIREMENT HOME	–	1
COUNCIL OF THE INSPECTOR GENERAL ON INTEGRITY AND EFFICIENCY	–	1
COURT SERVICES AND OFFENDER SUPERVISION AGENCY FOR THE DISTRICT OF COLUMBIA	5	14
DEPARTMENT OF AGRICULTURE	20	184
DEPARTMENT OF COMMERCE	3	10
DEPARTMENT OF DEFENSE	1	17
DEPARTMENT OF EDUCATION	2	43
DEPARTMENT OF ENERGY	6	37
DEPARTMENT OF HEALTH AND HUMAN SERVICES	115	1,006
DEPARTMENT OF HOMELAND SECURITY	1	6
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT	4	47
DEPARTMENT OF JUSTICE	7	48
DEPARTMENT OF LABOR	7	69
DEPARTMENT OF THE INTERIOR	–	2
DEPARTMENT OF THE TREASURY	3	23
DEPARTMENT OF TRANSPORTATION	4	35
ENVIRONMENTAL PROTECTION AGENCY	13	147
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION	4	35

Department	Number of Federal Personnel Deployed on 6/10/2021	Total Number of Federal Personnel Deployed From 3/1/21 to 6/10/2021
EXPORT-IMPORT BANK OF THE UNITED STATES	–	1
FARM CREDIT ADMINISTRATION	–	4
FEDERAL DEPOSIT INSURANCE CORPORATION	–	4
FEDERAL FINANCIAL INSTITUTIONS EXAMINATION COUNCIL	1	1
FEDERAL LABOR RELATIONS AUTHORITY	–	2
FEDERAL MARITIME COMMISSION	–	2
FEDERAL MEDIATION AND CONCILIATION SERVICE	–	4
FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION	–	1
FEDERAL TRADE COMMISSION	1	10
GENERAL SERVICES ADMINISTRATION	17	139
INTER-AMERICAN FOUNDATION	1	3
INTERNATIONAL BOUNDARY AND WATER COMMISSION: UNITED STATES AND MEXICO	–	2
NATIONAL AERONAUTICS AND SPACE ADMINISTRATION	1	6
OFFICE OF MANAGEMENT AND BUDGET	–	2
OFFICE OF PERSONNEL MANAGEMENT	4	31
PEACE CORPS	2	15
RAILROAD RETIREMENT BOARD	–	1
SOCIAL SECURITY ADMINISTRATION	67	319
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT	–	2
U.S. COMMISSION ON INTERNATIONAL RELIGIOUS FREEDOM	1	1
U.S. INTERNATIONAL TRADE COMMISSION	–	4
U.S. POSTAL SERVICE	–	2
GRAND TOTAL	290	2,263

Question. What steps has HHS taken to ensure that the individuals responsible for training new volunteers are knowledgeable about ongoing risks at UAC facilities, including the heightened risk of abuse and any ongoing safety concerns at the specific facilities where volunteers are being placed?

Answer. ORR's primary mission is to ensure the safety and well-being of the unaccompanied children in its care. ORR recognizes that children who enter ORR care may have experienced significant trauma not only in their home country but also during their journey to the United States. ORR staff have years of experience working with vulnerable populations and are knowledgeable about the specific needs of

children in ORR care. Individuals responsible for providing new trainings for detailees, such as the ORR's Prevention of Sexual Abuse (PSA) team, have years of experience as well as child welfare expertise. The PSA team is responsible for delivering trainings to all staff, detailees, contractors, and anyone who may have direct contact with children in ORR care.

Question. As you are aware, ORR is currently working to create of a new software program to replace the "Portal" that it uses to track reports of abuse and the movement of UAC through the system. When do you expect the software to be implemented, and are you confident that this program will address ongoing concerns with the Portal?

Answer. ORR has been working to improve the current system (the UC Portal) and planning to migrate to the new platform (the UC Path). ORR expects to begin a progressive, phased migration to a new environment in the fall of 2021, finishing in 2022. This includes monitoring the development and incorporation of data fields into the UC Path that will improve tracking and trending capabilities to better safeguard minors in ORR care. The UC Path is expanding the data point entries for incident report information as compared to the UC Portal. Long term, ORR is working with Department of Homeland Security (DHS) agencies in the development of the Unified Immigration Portal (UIP), which will connect DHS systems and ORR's UC Path system to strengthen interagency cooperation and communication in support of ORR's mission.

Question. In 2019, I passed the bipartisan Advancing Care for Exceptional (ACE) Kids Act with the help of Senator Bennet. It will align Medicaid rules and payment to incentivize coordination and improved health outcomes. This Congress, I am working with Senator Bennet to build onto ACE Kids Act with the Accelerating Kids' Access to Care Act that would streamline the screening and provider enrollment process for Medicaid providers serving children with complex medical conditions. The Centers for Medicare and Medicaid Services (CMS) noted its interest in streamlining provider enrollment and screening by acknowledging its ongoing Provider Enrollment, Chain, and Ownership System (PECOS) 2.0 activities in CMS's fiscal year 2022 budget justification *(https://www.cms.gov/files/document/fy2022-cms-congressional-justification-estimates-appropriations-committees.pdf).*

Do you believe CMS's PECOS 2.0 efforts align with the goals of the Accelerating Kids' Access to Care Act?

If so, can CMS provide technical assistance for the Accelerating Kids' Access to Care Act?

Answer. PECOS is the system of record for all Medicare provider/supplier enrollment data, which includes Part A, Part B, and DME. PECOS 2.0 is a ground-up redesign of the current system, and CMS is focused on modernizing the system to create an enterprise resource that is a platform for all enrollments across Medicare, Medicaid, and emerging provider programs. We are always happy to work with you to provide any requested technical assistance on legislation.

Question. The 2019 Advancing Care for Exceptional (ACE) Kids Act requires the Centers for Medicare and Medicaid Services (CMS) to issue guidance to State Medicaid directors on the coordination of care from out-of-state providers for children with medically complex conditions. CMS issued an request-for-information (RFI) in January 2020 to seek public comment *(https://www.federalregister.gov/documents/2020/01/21/2020-00796/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex).* The RFI was reopened for an additional 30 days in May and June 2020 *(https://www.federalregister.gov/documents/2020/05/04/2020-09392/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex).*

In follow-up to the RFI, CMS is required to issue guidance to State Medicaid directors, what is the status of CMS issuing guidance to State Medicaid directors?

If a status update on the guidance cannot be provided, what is the expected timeline to issue the guidance?

Answer. CMS is currently drafting guidance to States on the topics listed at section 1945A(e)(1) of the Social Security Act. The guidance is being informed by the information CMS received in response to its January 2020 Request for Information (RFI) entitled "Coordinating Care From Out-of-State Providers for Medicaid-Eligible Children With Medically Complex Conditions." We look forward to providing additional updates related to this guidance as they become available.

Question. The Centers for Medicare and Medicaid Services (CMS) reportedly only informs the public of fines imposed against nursing homes after the nursing homes are compelled to begin paying the fines (which can take some time, due to the availability of an appeals process). The Iowa Capital Dispatch reported this month:

> For most of the past year [CMS's] Care Compare website *(https://www.medicare.gov/care-compare/)* has falsely reported that the Dubuque Specialty Care nursing home in eastern Iowa had a perfect, deficiency-free inspection in June 2020. In fact, State inspectors found numerous, serious violations, and CMS imposed a fine of $84,825, which was immediately reduced to $55,136 once the home agreed to forego an appeal. . . .
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> [A]n agency spokesman in CMS' Office of Communications said "human error" had caused the agency to post a false deficiency-free inspection report for the Dubuque home on its website, though he was unable to say how or why such a report was created. As for the website's separate claim that the Dubuque home was never fined as a result of the June 2020 inspection, the spokesman attributed that assertion to the fact that "the facility has not yet begun to submit payments" toward the fine. He said CMS' "normal process" in cases of unpaid fines is to refer the matter to an administrative contractor who will initiate collection by offsetting Medicare payments owed to the home. "Once this begins, the fine will be reflected on the Care Compare website," the spokesman said.

My understanding is that the Department's Care Compare website includes information about fines that are imposed against nursing homes as a result of nursing home inspections that took place within the last three years. It's also my understanding that the imposition of the fines will typically remain undisclosed to the public during the sometimes lengthy period in which nursing homes exhaust the appeals process.

Is this an accurate statement of CMS's current policy?

If so, are there occasions on which nursing home fines may never be reported to the public because the process of appealing a fine can take more than 3 years to resolve?

If yes, how often does this actually occur in practice, that the imposition of a fine will never be disclosed on the Care Compare website?

What could CMS do to improve Care Compare to ensure that the public eventually gets access to this information?

Answer. CMS is committed to ensuring that every nursing home serving Medicare and Medicaid beneficiaries is meeting Federal requirements to keep its residents safe and provide high-quality care. A critical part of our efforts is providing the public with accurate and meaningful information about nursing homes, including inspection results and Federal fines or other penalties incurred as a result of a nursing home receiving a serious health or fire safety noncompliance citation. By using a Five-Star Quality Rating System, CMS's Care Compare website strives to provide residents and their families with an easy way to compare performance history between nursing homes and help them make important decisions about their care. It is critical for this information to be accurate and up-to-date, and CMS continues to improve the Care Compare website and the Five-Star Quality Rating System.

As part of the provider's due process rights, States are required to offer an opportunity for informal dispute resolution (IDR). The IDR process was implemented to ensure that facilities receive a fair and appropriate decision based on evidence. It is important to note that while the IDR process generally takes about 60 days to complete, enforcement actions and corrections of noncompliance are not delayed during this period. CMS posts the results of surveys online after the IDR is completed to allow the process to conclude and to ensure that the findings reflected are accurate. In addition to initiating an IDR, providers have the option to formally appeal the noncompliance citation that led to enforcement actions. Although the process of appealing a citation may take months or even years, CMS wins the vast majority of these cases and posts deficiencies on Care Compare even while they are being appealed. Like all complex data reporting systems, Care Compare may occasionally experience data entry or display issues. Once CMS becomes aware of these errors, including errors that prevent some deficiencies from being properly displayed, the agency works to correct them as quickly as possible. CMS has a robust quality assurance process and is always looking to improve its systems. I look forward to

working with you and stakeholders across the industry to address these issues and continue to improve the Care Compare website.

Question. The Iowa Capital Dispatch reported recently:

> The list of the Nation's worst-performing nursing homes, compiled by the Federal Centers for Medicare and Medicaid Services (CMS), is known as the special-focus facilities list *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFF List.pdf),* and is updated quarterly. The special-focus facilities are those deemed by CMS to have "a history of serious quality issues" and they are enrolled in a special program that is intended to stimulate improvements in their quality of care through increased oversight. However, five of the 12 Iowa homes that are either currently designated special-focus facilities or are eligible for that designation based on their poor performance, have maintained that status for at least two years.
>
> Nationally, the number of facilities on the list remains relatively constant: There are normally about 88 nursing facilities, with one or two slots to be filled by each State. The Iowa Department of Inspections and Appeals nominates the Iowa facilities for inclusion on the list, and CMS selects two from the State to be enrolled in the program. In addition to Iowa's two special-focus facilities, there are 10 Iowa homes that qualify for inclusion on the list based on their poor performance. In order for any of those 10 to be designated a special-focus facility and receive the added regulatory oversight that comes with it, one of the two currently designated homes first must graduate from the list. Typically, homes that are eligible for the special-focus designation have about twice the average number of violations cited by State inspectors; they have more serious problems than most other nursing homes, including harm or injury to residents; and they have established a pattern of serious problems that has persisted over a long period of time.

My understanding is that the Nation's poorest performing nursing homes are enrolled in the Department's "special focus facilities program," which is designed to help those facilities improve, and that some of these poor performers will remain enrolled in the program for years. It's also my understanding that other poorly performing nursing homes may be eligible for the program, but cannot become a special focus facility until another facility successfully completes the program. The media also reported some time ago that a significant number of the nursing homes that successfully emerge from the program will later be cited for instances of serious harm to residents or for placing residents in immediate jeopardy.

How many special focus facilities are there right now, how many of those facilities have been enrolled in the program for more than a year, and how many are eligible for inclusion in the program but are not enrolled?

What can you tell me about this administration's plans, if any, to improve the special focus facilities program?

Answer. 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. The Special Focus Facility program was established to address facilities with compliance history that have often not addressed the underlying systemic problems that result in repeated cycles of serious deficiencies. When a Special Focus Facility slot is open due to the termination or graduation of a facility in the Special Focus Facility program, the State agency must select a new facility from the candidate list for the program supplied by CMS. The names of candidates are issued monthly along with the Five-Star Quality Rating updates.

As of June 2021, there are currently 86 special focus facilities and 51 of these facilities have been enrolled in the program for more than a year. In addition, there are also 442 nursing homes considered special focus facility candidates. This latest information is posted on the CMS website at: *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFF List.pdf.* I am committed to working with you and your colleagues to hold nursing homes accountable for providing high quality of care to their residents.

Question. Access to emergency and primary health care services is a basic quality of life issue for a resident of any sized community. Section 125 of Public Law (Pub. L.) 116–260 established the Rural Emergency Hospital (REH) voluntary Medicare payment designation. This bipartisan solution will support struggling rural hos-

pitals by allowing them to voluntarily right-size their health-care infrastructure while maintaining essential medical services for their rural communities. A recent Government Accountability Office (GAO) report found more than 100 rural hospitals have closed in 28 different States since 2013. The COVID–19 pandemic has only further strained rural hospital finances. If nothing is done, more hospitals and rural Americans will continue losing access to essential medical services resulting in poorer outcomes and higher costs for patients and taxpayers. The REH designation offers the flexibility to support rural hospitals that can no longer support inpatient services while maintaining services that better align with the specific needs of their patient population including 24/7 emergency care, outpatient care, ambulance services, and more. It is important that Federal regulations and guidance adequately consider the needs of rural providers. Recently, Senator Klobuchar and I sent a letter to the Centers for Medicare and Medicaid Services (CMS) asking the agency to prioritize the implementation of this law by establishing a project lead at CMS to ensure a timely and stakeholder-driven implementation. In CMS' fiscal year 2022 budget justification it stated, "CMS will engage with stakeholders through the rulemaking process in implementing this provision."

Has CMS established a project lead at CMS to implement section 125 of Public Law (Pub. L.) 116–260?

If not, what is the timeline to establish a project lead or process to implement section 125 of Public Law (Pub. L.) 116–260?

Answer. Section 125 of the Consolidated Appropriations Act (CAA) of 2021 requires that Rural Emergency Hospitals (REHs) be eligible for Medicare payment for services furnished on or after January 1, 2023. CMS continues to work diligently to ensure that the REH program is fully implemented by the statutory date. CMS is coordinating with the HHS Office of Rural Health Policy on the REH program and will be issuing a request for information to better inform rulemaking. CMS remains steadfast in its commitment to address the recent closures of rural hospitals and ongoing access to health-care services in rural communities and is focused on implementing the REH provision of the CAA by the statutory deadline.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. On May 12, 2021, during a virtual hearing before members of the House Energy and Commerce Committee, you repeatedly refused to acknowledge that partial-birth abortions are illegal in the United States, though they have been since 2003. My colleague, Senator Steve Daines of Montana, asked you to clarify during the Finance hearing on the FY 2022 budget. Unfortunately, you still refused to plainly State that partial birth abortion is illegal. As such, please answer the following questions, clearly, directly, and fully.

Do you agree that partial-birth abortion, as defined in 18 U.S. Code § 1531 is illegal and punishable by fine, imprisonment or both?

Do you agree with the Supreme Court decision to uphold the ban on partial-birth abortions in *Gonzales v. Carhart?*

Do you agree that partial-birth abortions are a particularly grotesque method of late-term abortions?

Will you commit, as Secretary of Health and Human Services, to fully upholding and enforcing this law in conjunction with the Department of Justice?

Answer. As stated during confirmation hearings, the Department will follow all applicable laws as they relate to abortion and any other issue.

Question. Current Federal law prevents funds from being used to pay for abortions in most circumstances. Unfortunately, in the partisan COVID response bill passed in March, my Democratic colleagues refused to include the Hyde Amendment.

What specific steps you are taking to ensure that funds previously enacted under FY21 appropriations and all of the COVID relief bills that included Hyde restrictions are kept separate from all funding passed under the American Rescue Plan?

Answer. As part of overall tracking of regular vs. emergency appropriations, OMB directs agencies to separately track emergency appropriations. HHS accomplishes that by fully segregating these funds in its accounting records and grants systems.

Question. During the committee's hearing on the FY 2022 HHS budget, and during your nomination hearing, I asked whether you intended to maintain the Conscience and Religious Freedom Division within the Office for Civil Rights. Your answers during both the nomination hearing and FY 2022 budget hearings lacked clarity. As such, please answer the following questions, clearly, directly and fully.

Will you commit to supporting and preserving the Conscience and Religious Freedom Division's existing role, delegations, and authorities in enforcing all conscience and religious freedom laws applicable to HHS?

Will you respect the authority of the career professionals in the Conscience and Religious Freedom Division to receive complaints, investigate cases, and make findings independent of and without interference or blocking from you or any personnel or political appointees under you?

Will you commit to not dismantling, eliminating, or materially diminishing the Conscience and Religious Freedom Division and to prohibiting any personnel or political appointee under you from doing the same?

Will you commit to not transferring, reassigning, or dismissing any staff from the Conscience and Religious Freedom Division against their will unless justified by bona fide and documented performance or misconduct reasons?

Answer. As I stated during my hearing, HHS will continue to protect the religious, civil, and constitutional rights of all Americans under HHS's purview under our Office for Civil Rights. This means that we will enforce conscience and religious freedom activities, including receiving complaints, investigating cases, and making findings consistent with the law.

Question. As you know, the previous administration disallowed $200 million in Medicaid funds from California because it was literally forcing nuns to buy abortion insurance in violation of conscience protection laws.

Will you commit to not reversing the findings made by career professionals supporting the disallowance, and will you commit to not restoring the money to California?

Answer. In my ethics agreement signed on January 17, 2021, and the subsequent authorization issued on March 31, 2021, I have agreed not to participate in any litigation involving the State of California that was pending during my tenure as Attorney General. I understand that there has been no litigation on this matter, however, as Attorney General I did issue a public statement on the matter. After consulting with the HHS Acting Designated Agency Ethics Official, I have determined that it is prudent for me to recuse myself from this Medicaid financing matter to avoid even an appearance of impropriety.

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) completed a review of its January 24, 2020, Notice of Violation (2020 NOV), against that the State of California and the California Department of Managed Health Care (DMHC). On May 14, 2021, CMS withdrew its January 15, 2021, Medicaid disallowance imposed on the State due to an underlying finding of the State's "continued non-compliant status under the Weldon Amendment." As noted by CMS, California's March 15, 2021, Request for Reconsideration of the Medicaid disallowance raised issues related to OCR's underlying Weldon violation determination; CMS thus referred the matter to OCR for further review.

Having completed its review of the 2020 NOV, OCR withdrew its 2020 NOV and closed the complaints filed with OCR, on which the 2020 NOV was based. More information on this matter can be found here: *https://www.hhs.gov/conscience/conscience-protections/ca-letter/index.html.*

Question. During your nomination hearing, you acknowledged potential conflicts of interest related to your activities as California Attorney General, but did not provide the committee with an explicit list of the relevant cases and matters to which you must be recused.

As such, please list all cases and matters, including lawsuits, amicus participation, investigations, administrative matters, regarding which you have recused, or will recuse, yourself. Please include all matters where you were a named respondent or were listed on the papers and include full captions or titles, case, complaint, or matter numbers, courts or agencies of jurisdiction and a full description of the subject matter from which you will recuse yourself from in each matter or case identified.

Answer. As Secretary, I provide leadership and direction for the very talented employees of the Department who, at the working level, handle the vast amounts of work, including specific litigation matters. Pursuant to my ethics agreement signed on January 17, 2021, and the subsequent authorization issued on March 31, 2021, I am not participating in any litigation involving the State of California that was pending during my tenure as Attorney General.

Question. A few weeks ago your agency announced, without going through any sort of formal rule-making process, that HHS will interpret prohibitions on sex discrimination in health care to include "sexual orientation and gender identity."

Is it your intention to require doctors, hospitals, or medical staff to participate in or perform gender transition procedures on any patient, including a child, even if the doctor, hospital, or medical staff believes the procedure would be harmful or it is against their religious beliefs?

Will you protect the religious beliefs of doctors and medical staff who object to participating in practices where they have a medical, conscience or religious objection?

How does this interpretation impact the medical treatment of patients in instances where biological sex is pertinent to treatment, such as pregnancy and child birth?

Will you commit to ensuring taxpayer dollars are not used to fund gender reassignment procedures, including puberty blockers and cross-sex hormones on children?

Answer. As I stated during my hearing, HHS will continue to protect the religious, civil, constitutional rights of all Americans under HHS's purview under our Office for Civil Rights. This means that we will enforce conscience and religious freedom activities, including receiving complaints, investigating cases, and making findings consistent with the law.

Question. While new purchases are being made by the administration to send overseas, millions of Federal dollars invested in vaccine development and distribution are being literally poured down the drain due to States having more supply than demand.

What is the administration's plan to facilitate the redistribution of vaccines currently in the hands of States before they expire?

Answer. FDA has continued to monitor the available data and has announced shelf life extensions of COVID–19 vaccines numerous times. HHS is also encouraging States to monitor their orders of vaccine and utilize vaccines on hand prior to ordering additional doses.

Question. According to the fiscal year 2022 budget justification estimate sent to Congress by HHS, pharmacy DIR fees increased by 91,500 percent between 2010 and 2019. This is unsustainable for community pharmacies nationwide, many of whom serve underserved populations and demands action by Congress and the administration. I recently introduced bipartisan legislation with Senators Capito, Tester, and Brown to address pharmacy DIR fees.

Can HHS provide us with more data to break down the yearly increase of DIR fees so that we can better understand these dramatic increases and their negative impact on small business pharmacies and the patients they serve?

Moreover, are the cost increases over the last decade enough justification for HHS to finalize reform of pharmacy DIR fees?

Answer. Given the significant growth in pharmacy price concessions in recent years, when such amounts are not reflected in the negotiated price, it has become increasingly difficult for consumers to know at the point-of-sale what share, or approximate share, they are paying of the plan's cost for their prescription drugs. I look forward to working with Congress to improve transparency and competition in the Part D program.

Question. I share your commitment to making prescription drugs affordable for patients. Dating back to the Senate Finance drug pricing markup in 2019, I have been working on policies that support appropriate formulary placement of generics and biosimilars in Medicare Part D. One of the key barriers to access to these affordable medications is formulary design. I think this is a critical issue to ensuring that generics and biosimilars are covered on Part D plans and are included on the

lower-cost sharing tiers so that beneficiaries actually receive the benefit of these affordable medicines.

Last year, CMS finalized a policy to create a second specialty drug tier with reduced cost-sharing for beneficiaries. This is an important step forward, but more must be done to ensure newly approved generics and biosimilars are added to lower-cost sharing tiers.

Will you commit to working with me on this issue to ensure Medicare beneficiaries get access to these affordable medications and benefit from the savings?

Answer. Prescription drug costs are too high for American patients and families. From the meetings I have had with Senators, 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 and biosimilars certainly have a role to play in creating competition for reference products. I look forward to working with you and your colleagues to lower the cost of prescription drugs.

QUESTIONS SUBMITTED BY HON. BEN SASSE

Question. Two thousand, eight hundred providers in Nebraska have received $873 million from the Provider Relief Fund, which many providers continue to rely on to stabilize lost revenue from the early days of the pandemic. I have heard from many who are grateful for last week's announcement from the Health Resources and Services Administration extending reporting timelines.

Could you share any information about where HHS is at on evaluating the timing and formula for the remaining funds in the Phase 4 distribution?

Answer. HHS is working on approaches to distribute Provider Relief Fund funding as quickly and equitably as possible while maintaining effective safeguards for taxpayer dollars. HHS is considering feedback from Congress and stakeholders, as well as operational lessons learned from prior PRF payments, as part of this process. The Provider Relief Fund also continues to make claims reimbursement to health-care providers for COVID–19 testing, treatment, and vaccine administration services for the uninsured, and COVID–19 vaccine administration for the underinsured. Additional information on future distributions will be published on HHS's Provider Relief Fund webpage, at *www.hhs.gov/providerrelief,* as soon as it becomes available.

Question. At many points in last week's hearing you discussed the administration's decision not to include the Hyde Amendment in the FY 2022 budget.

While we have already discussed our differences in opinion on this decision, can you elaborate on the decision-making process that led to this elimination and what data was used in that determination?

Answer. I am not in a position to share the pre-decisional discussion with the Executive Office of the President.

Question. The FY 2022 budget calls for an increase in funding for the National Institutes of Health, which I have supported in the past. I am concerned, however, about the NIH's recent announcement that it will no longer convene an Ethics Advisory Board to review research applications seeking funding for projects which use human fetal tissue and that projects using this tissue would resume without limitation. These restrictions were put in place after serious ethical concerns were brought to light, including one contract where researchers used Federal funding to pay up to $2,000 for fully-intact infant bodies aborted in the second trimester.

Without the Ethics Advisory Board, how will HHS determine whether taxpayer dollars are being used for unethical or even illegal research practices? Can you elaborate on this process?

Will you commit to working with Congress to ensure that the Ethics Advisory Board is reinstated or that NIH policy governing research using human fetal tissue is strengthened?

Answer. NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and apply that knowledge to enhance health, lengthen life, and reduce illness and disability. Under its broad research mission, and as authorized by the Public Health Service Act, NIH conducts and funds research involving the study, analysis, or use of human fetal tissue for a range of diseases and con-

ditions. NIH also funds research to develop, demonstrate, and validate experimental models that are alternatives to the use of human fetal tissue.

On April 16, 2021, NIH published an Update on Changes to NIH Requirements Regarding Proposed Human Fetal Tissue Research (NOT–OD–21–111),[3] stating that HHS was reversing its 2019 decision that all research applications for NIH grants and contracts proposing the use of human fetal tissue from elective abortions will be reviewed by an Ethics Advisory Board. Accordingly, HHS/NIH will not convene another NIH Human Fetal Tissue Research Ethics Advisory Board. Please note that all other requirements described in NOT–OD–19–128[4] and updated in NOT–OD–19–137[5] for extramural research remain unchanged. Furthermore, NIH reminded the community of expectations to obtain informed consent from the donor for any NIH-funded research using human fetal tissue, and of continued obligations to conduct such research only in accord with any applicable Federal, State, or local laws and regulations, including prohibitions on the payment of valuable consideration for such tissue.[6] The same requirements apply to the intramural program.

All NIH-supported organizations certify that they will comply with the NIH Grants Policy Statement,[7] which summarizes NIH policies regarding the use of human fetal tissue in research and incorporates Federal statutory requirements for research with human fetal tissue (sections 498A and 498B of the PHS Act, 42 U.S.C. 298g–1 and 298g–2).

Question. On May 15, 2021, *Politico* reported that HHS took approximately $2.13 billion in funding that Congress had primarily appropriated for combating COVID–19 and redirected it to the crisis at the southern border.[8] These diverted funds included (1) $850 million that was initially appropriated for rebuilding our Strategic National Stockpile; (2) $850 million that was appropriated for expanding COVID–19 testing; and (3) $436 million from "a range of existing health initiatives across the department."[9]

On May 12, 2021, a few days before this news was released, you testified before the House Energy and Commerce Committee's Subcommittee on Health regarding HHS's budgetary needs for FY 2022. In this testimony, you stated that HHS required $905 million for replenishing the Strategic National Stockpile to "ensure the stockpile is ready to respond to future pandemic events and any other public health threats."[10]

Did HHS divert $1.7 billion in COVID–19 testing and national stockpile funds to assist the crisis at the southern border?

Answer. All HHS actions were carried out under explicit authority provided by the Congress. For example, the discretionary COVID supplementary appropriations included explicit authority to transfer funds as necessary among certain Operating Divisions of HHS to cover costs incurred as a result of COVID–19.

Question. If yes, how will these funds be replenished moving forward?

Answer. The American Rescue Plan Act of 2021 provided $6.05 billion for research, development, manufacturing, production, and the purchase of vaccines, therapeutics, and ancillary medical products and supplies to prevent, prepare, or respond to COVID–19 or any disease with pandemic potential. Of this amount, $850 million was allocated to the SNS to procure supplies to respond to the COVID–19 pandemic.

Question. Are the current resources in the Strategic National Stockpile sufficient to meet our PPE and medical supply needs?

Answer. Using supplemental funding, the Strategic National Stockpile has vastly increased its inventory of PPE, ancillary medical supplies, pharmaceuticals, and ventilators to meet the national demand. Funds continue to increase production ca-

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[3] *https://grants.nih.gov/grants/guide/notice-files/NOT-OD-21-111.html.*
[4] *https://grants.nih.gov/grants/guide/notice-files/NOT-OD-19-128.html.*
[5] *https://grants.nih.gov/grants/guide/notice-files/NOT-OD-19-137.html.*
[6] *https://grants.nih.gov/grants/guide/notice-files/not-od-16-033.html.*
[7] *grants.nih.gov/grants/policy/nihgps/HTML5/introduction.htm.*
[8] Adam Cancryn, "Biden administration reroutes billions in emergency stockpile, COVID funds to border crunch," *Politico* (May 16, 2021), *https://www.politico.com/news/2021/05/15/hhs-covid-stockpile-money-border-migrants-488427.*
[9] *Id.*
[10] The Fiscal Year 2022 HHS Budget Before the Subcommittee on Health of the House Committee on Energy and Commerce, 117th Congress 2 (2021) (statement of Xavier Becerra, Secretary of Department of Health and Human Services).

pacity of PPE and other medical supplies and treatments for acquisition into the Stockpile and to support product distributions to impacted States.

Question. Was the $905-million budget request for the Strategic National Stockpile calculated before or after the $850 million in existing funds for the stockpile were repurposed to assist with the crisis at the southern border?

Answer. The budget includes $905 million for the SNS to make meaningful investments across a number of portfolios necessary to ensure readiness for future public health emergencies. Funds would also be used to support SNS's ongoing storage and distribution needs, which were expanded and modified to meet the demands of the COVID–19 pandemic. These activities are separate from on-going COVID response activities which have largely been supported by supplemental appropriations.

Question. The budget also requests $3.3 billion for the Unaccompanied Children Program, a $2-billion increase, or more than double the previous amount.

Is the program currently housing more than double the number of children as it was previously?

Answer. The Unaccompanied Children (UC) Program received an unprecedented number of children in the spring of 2021. On April 28, 2021, ORR reported a census of nearly 23,000 children in care, and migration trends continue to drive an increase in resource needs in this program. The UC Program receives funding from Congress that is available to obligate over a 3-year period, allowing unused funds in 1 year to be carried over and obligated in the next 2 years. About $1.3 billion was carried over from FY 2020 into FY 2021, primarily due to the availability of 2019 supplemental appropriations during FY 2020. While the budget is requesting a $2 billion increase in appropriations, the budget also shows that year to year spending is expected to increase from $2 billion in FY 2020 to $3 billion in FY 2021 and to $3.5 billion in FY 2022. (See printed page 63, or pdf page 68 of the FY 2022 budget request: *https://www.acf.hhs.gov/sites/default/files/documents/olab/fy_2022_congressional_justification.pdf.)*

Question. What is the current number of children in HHS custody?

Answer. As of June 10, 2021, there are 16,487 children either physically resident in ORR programs or en route to ORR custody from CBP.

Question. Will these funds be used to support the children without a sponsor who end up in the U.S. foster care system?

Answer. No. Funds are not used to transfer unaccompanied children into the U.S. domestic foster care system. While ORR long-term foster care families are licensed by the State to serve as foster families, and must adhere to State licensing regulations, ORR long-term foster care programs are not State-funded and are not part of the State child welfare system. Please see ORR Policy 3.6 ORR Long-Term Foster Care for additional information. Further, the funding request is not related to the ORR unaccompanied refugee minor (URM) program, which serves several eligible populations including paroled unaccompanied Afghan minors.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Currently, Medicare has a statutory exclusion on Medicare coverage of dental care and routine dental services like x-rays and cleanings. For the two-thirds of elderly beneficiaries and individuals with disabilities under Medicare, this means their access to care is incomplete.

Establishing a Medicare dental benefit has been a priority of mine for a number of years, and earlier this year I introduced legislation again, along with Senators Brown and Casey, that would create a dental benefit under Part B to improve the health of our Medicare beneficiaries. Recently, I and a number of my colleagues, including Senators Stabenow and Sanders, wrote to President Biden urging that Medicare benefits be expanded to include dental care. I am also pleased that the President Biden's budget supports strengthening Medicare by improving access to dental, hearing, and vision coverage for beneficiaries.

What are the administration's next steps to establish a dental benefit in Medicare?

Answer. Thank you for your leadership on this important issue. Oral health is a critical part of overall health and I look forward to working with you on these issues. President Biden supports making dental coverage a standard benefit in

Medicare. I know this is an important issue to you, and I look forward to working with you on the legislation needed to expand access to dental care in Medicare.

Question. I am glad the FY 2022 budget proposes $100 million for the CDC to establish a new Community Violence Intervention (CVI) initiative, in collaboration with DOJ, to support evidence-based community violence interventions at the local level. Hospital-based interventions are among the most effective within this category.

By providing services for victims of violent crime while they are recovering from their injuries, these programs equip survivors to make lifestyle changes that prevent them from being re-victimized and reduce their likelihood of being involved in future violence. The program at the University of Maryland Medical Center's Shock Trauma Center has demonstrated impressive results. However, there are few Federal resources available for this work.

I will introduce legislation, the End Cycle of Violence Act, which would create HHS grants for hospital-based violence intervention or prevention programs. The bill would use Federal funds to establish or expand operations and study their effectiveness. The House of Representatives last month passed a companion bill, introduced by my colleague Congressman Ruppersberger, with strong bipartisan support.

Could you speak about the administration's decision to start this new Community Violence Intervention Initiative?

Answer. The proposed Community Violence Intervention Initiative is an opportunity to help create safe communities by meeting communities where they are based on the needs and priorities they identify and assisting them with the implementation of proven prevention strategies that have been shown to reduce serious and lethal violence, arrests, aggression, substance use, and other behavioral risks.

The additional $100 million in the President's Budget request will be dedicated to a new evidence-based community violence intervention initiative. CDC will support implementation of evidence-based and innovative evidence-informed violence prevention strategies with the greatest potential in communities most impacted by community violence in four ways:

1. CDC will support implementation of evidence-based violence prevention strategies with the greatest potential in the 25 cities with the highest overall number of homicides and the 25 cities with the highest number of homicides per capita.
2. Beyond the five National Centers of Excellence in Youth Violence Prevention that CDC currently funds, CDC will fund an additional 24 research awards using all available funding mechanisms to further build the evidence base for preventing violence in those communities experiencing the greatest burden of youth and community violence, and to reduce the racial, ethnic, and economic inequities that characterize such violence across our country.
3. Supporting up to five non-governmental organizations that have expertise in partnering with communities most impacted by community violence.
4. Modernize data systems to enhance the ability of States, cities, and communities to monitor youth and community violence in real time. This will include improvements to the National Violent Death Reporting System.

Question. In light of estimates that gun violence costs taxpayers billions of dollars annually, can you comment on the potential returns on these investments?

Answer. Community violence interventions have a large potential for return on investment. There are multiple sources for substantial savings, including direct reductions in law enforcement costs, as well as prosecution, corrections, medical, counseling, and employee productivity costs, to less direct benefits for the educational system, local business, and property values. These benefits are in addition to reductions in the pain and suffering to victims, their families, and friends. Studies to quantify returns on investment from violence prevention strategies vary widely in their approaches but generally find that the benefits outweigh the costs.

Question. In establishing new Federal funding sources for these programs, why is it important to leave room for local flexibility?

Answer. Hospital-based violence prevention programs are a promising strategy to reduce repeat and future risk of firearm victimization and perpetration. By strengthening the connections between the acute treatment of violence-related injuries and community services and supports, these approaches help lessen trauma, in-

crease situational awareness and skills, and reduce co-occurring behavioral and social risks. Tailoring a program to the local context helps ensure success. These types of approaches produce better results when they can draw upon credible messengers from the local community with training and/or lived experience, when there is administrative support and resources within the hospital to support the program, and when there are strong partnerships between hospitals and organizations in the community offering a wide array of services and supports to address the needs of clients. Leaving room for local flexibility is important as it guards against a one-size fits all approach which would be inconsistent with the aims of these programs.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. Thank you for your, and Deputy HHS Secretary Palm's, commitment to working with me to help support rural communities in Colorado, including through regulatory and financial relief for rural hospitals and providers. I also appreciate the funding for community health and hospital resilience infrastructure in the FY 2022 budget request. I am concerned that there was not specific funding for rural hospital and provider infrastructure.

Can you explain how you intend to specifically support rural hospitals' infrastructure needs, like that of Lincoln Health, in Hugo, CO—which represents the only access to acute care services within a 70-mile radius, yet does not have private rooms and showering facilities—through the FY 2022 HHS budget?

Answer. The Hospital Preparedness Program (HPP) supports efforts to strengthen health-care sector readiness to provide coordinated, life-saving care in the face of emergencies and disasters. The HPP portfolio supports a comprehensive, national network for health-care preparedness and response. The programs and activities within the HPP portfolio are coordinated to address the many, complex facets of the Nation's health-care system, creating mechanisms and infrastructure to improve coordination between localities, States, and regions, as well as developing new capabilities (*e.g.,* telemedicine, specialty health care, etc.) specific to key challenges within the modern threat landscape (*e.g.,* highly pathogenic disease, biological/chemical incidents, etc.).

As the primary source of Federal funding for health-care system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and to enable rapid health-care service resilience and recovery. Since 2002, investments administered through HPP have improved individual health-care entities' preparedness and have built a system for coordinated health-care system readiness and response through health-care coalitions (HCCs) and other partnerships, such as the Regional Disaster Health Response System (RDHRS) demonstration project. With respect to infrastructure needs, recipients of funding are expected to consider how to provide and plan for uninterrupted care when faced with damaged or disabled health-care infrastructure during an emergency response; however, the HPP cooperative agreement does not allow for construction or major renovation costs.

HPP provides cooperative agreement funding to States to support health-care system preparedness efforts. Specific to Colorado, if appropriated at the requested level in Fiscal Year 2022, it is estimated that Colorado will receive $3,584,461 via the HPP cooperative agreement. Colorado will delegate this funding within the State to support such efforts, including enhancing rural capabilities.

Additional ASPR Programs and Tools Concerning Colorado and Rural Health:

- The Denver Health and Hospital Authority was also recently awarded the Partnership for Disaster Health Response System Cooperative Agreement to establish the Region 8 Mountain Plains RDHRS demonstration site. To address gaps in regional health-care delivery during disasters, ASPR developed the RDHRS: a tiered system that builds upon and unifies existing health-care and ASPR assets within States and across regions that supports a more coherent, comprehensive, and capable health-care disaster response system able to respond to health security threats. The RDHRS helps improve disaster readiness capabilities and capacity, increase medical surge capacity, and extend provision specialty care—including trauma, burn and infectious disease, among others—during large-scale disasters or public health emergencies.
- Additionally, the Rural Health Care Surge Readiness Portal was established in 2020 to provide the most up-to-date and critical resources for rural health-

care systems preparing for and responding to a COVID–19 surge. The resources span a wide range of health-care settings (including EMS, inpatient and hospital care, ambulatory care, and long-term care) and cover a broad array of topics ranging from behavioral health to health-care operations to telehealth. This portal was developed by the COVID–19 Healthcare Resilience Working Group, a partnership with the Department of Health NS Human Services, the Department of Homeland Security, and other Federal agencies, to provide support and guidance for health-care delivery and workforce capacity and protection.

Question. I am also concerned with the revised reporting requirements for the Provider Relief Fund (PRF) released by HHS on June 11, 2021. I appreciate the Department granting more flexibility to providers who received funds after June 30, 2020, and the extension of reporting requirement deadlines. However, the revised guidance fails to address the concerns of providers we have heard from who received PRF funds prior to June 30, and who will be required to repay those funds if not utilized by June 20, 2021.

While the country is certainly making strides towards ending this pandemic, it is not over. I have heard from rural providers across Colorado who are still struggling to get back on their feet, and for whom this crisis will continue long past June of this year. By leaving in place the repayment requirement for unused funds, providers (including rural hospitals, rural health clinics, and Federally Qualified Health Centers) will have to repay the money intended to help them navigate this once in a century pandemic, even when cases in certain rural counties are rising.

The Department, June 16, 2021, has stated that, "HRSA will not be providing alterations to the [repayment] policy at this point."

- Can you explain how the FY 2022 HHS budget ensures that rural hospitals, who may need these funds to support needs related to COVID–19, will provide the hardest hit hospitals in Colorado with the support they need?
- Would you work with HRSA to amend this policy, especially for rural hospitals and providers, who might need the regulatory and financial relief that we talked about prior to your confirmation?

Answer. Please note that PRF recipients may use payments for eligible expenses or lost revenues incurred prior to receipt of those payments (*i.e.,* pre-award costs) so long as the funds are to prevent, prepare for, and respond to coronavirus. It is the obligation (or incurred) date that determines whether the expense is an allowable cost, not the date of possession. If the purchase occurred within the period of availability, but the item was received after the period of availability, it would still be considered an allowable cost. The provider will need to maintain adequate supporting documentation to show that the expense is attributable to coronavirus and was incurred within the period of availability. Providers must retain supporting documentation for 3 years.

HHS has also hosted webinars to provide technical assistance to providers. The recordings are made available online at *https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html.* We also encourage providers to contact the provider support line—HHS will now provide second tier technical assistance for providers and will communicate directly with them to walk through their questions. The number is (866) 569–3522; for TTY dial 711. Hours of operation are 7 a.m. to 10 p.m. Central Time, Monday through Friday.

Question. Over the past year, I have been working with Senator Todd Young on a proposal to address the issue of antimicrobial resistance. According to the CDC, each year in the U.S., at least 2.8 million people suffer from an antibiotic-resistant infection, and more than 35,000 people die—many of these are Medicare beneficiaries. Over the course of the past year, secondary infections from COVID–19 hospitalizations and other types of infections in nursing homes became a concern. In my mind, there are a few issues: the first is stewardship—underusing or overusing antibiotics inappropriately. The second is the lack of antibiotic development for drugs that treat resistance infections. According to the World Bank, this could reduce the global economy by trillions of dollars in less than a decade.

That is why Senator Young and I are working on the PASTEUR Act. This legislation creates a new model on how to pay for novel antibiotics for Americans who receive their health insurance through Federal health programs. I am glad that the budget increases funding for development of antibiotics, but, due to market failures and broken reimbursement system, many of those companies receive FDA approval

and then have to shut down. I understand this was economic incentives for antibiotic development was an important topic at the Group of Seven Health Ministers meeting a few weeks ago.

Can you explain your commitment to address antimicrobial resistance through economic incentives for development, including the model proposed in the PASTEUR Act, and why this was not reflected in the FY 2022 budget?

Answer. Thank you for your leadership in this area. The increase in serious antimicrobial drug resistant infections is a significant public health threat. It jeopardizes many areas of progress in modern medicine, such as cancer treatment, organ transplantation, and other surgical procedures that are often associated with microbial infection complications—and leaves some patients with few or no good treatment options. Antimicrobial stewardship efforts can help slow the development of new resistance and aggressive containment efforts can help stem its spread. However, new antimicrobials are and will continue to be needed to treat infections caused by resistant bacteria and fungi.

Congress passed legislation as a part of the Food and Drug Administration Safety and Innovation Act (FDASIA) and the 21st Century Cures Act to incentivize antimicrobial development, facilitate development of drugs for the most difficult to study infections, and streamline the updating of breakpoints in antimicrobial labeling. Real advances have occurred as a result of these initiatives. Unfortunately, reports suggest companies focused on antimicrobial drug development are struggling economically even after the approval of a new antibacterial drug. The emerging consensus is that a multifaceted approach towards antimicrobial drug development is needed, including incentives large enough to overcome the economic realities of developing and marketing a new antimicrobial drug.

The PASTEUR Act seeks to incentivize development of antimicrobial products by establishing an antimicrobial subscription model to encourage the development of innovative antimicrobial drugs and address the economic issues that companies have grappled with in the antibacterial space after approval by creating a guaranteed reimbursement level for certain antimicrobial drugs. We are happy to continue working with you on this important legislation.

QUESTION SUBMITTED BY HON. JOHN THUNE

Question. In Fall 2019, HHS published a report on strategies for IT modernization for the Indian Health Service. This report included a lot of key work that was projected to occur in 2020 and 2021. This budget proposes to increase funding for updating IHS's electronic health record system, which will be a key part of IT modernization.

Is the Department's strategic plan for modernization still on track, or should we anticipate delays in progress due to the pandemic?

Answer. The 2019 Health IT Modernization Research Project informed the Department of Health and Human Services (HHS) and Indian Health Service (IHS) efforts to modernize the IHS Health Information Technology (HIT) system. The research project identified estimated timelines and approaches to HIT modernization. The final report identified risks and challenges for IHS regarding recurring funding for Health IT, (IHS HIT Final Report, pg. 15, pg. 26).

In 2020, IHS implemented the Project Management Office, released the 2015 ONC Certified Edition of RPMS, and tested interoperability with the VA. Additionally, IHS addressed COVID–19 testing surveillance and vaccine reporting as part of the pandemic response.

IHS is currently developing the acquisition plan and will realign the timeline estimates based on the completed planning, listening sessions, and industry engagement. IHS does not expect significant delays in the Project due to the COVID–19 response.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. Earlier this year I sent a letter to you and Secretary Cardona asking about how HHS and the Department of Education plan on working together to equip schools to address kids' mental health needs. I appreciate the handful of examples in your response where your agencies are collaborating, and I encourage you

to continue working closely with Ed to support students' mental health and well-being.

What will the administration deem as success in addressing kids' mental health needs?

Answer. In deeming success in addressing kids' mental health needs, HHS will prioritize having children and youth feel safe in their homes, their schools, and their communities. In addition, the administration will make investments so that children and youth receive mental health literacy and prevention services through an integrated social emotional learning curriculum within their school. Through the administration's policies to expand access to health care, children and youth who need clinical intervention will have access to community or school based mental health services. Lastly, children and youth who need intensive intervention, should receive intensive services so that they are able to remain with family and thereby reducing the need for foster care, inpatient, residential (juvenile justice and/or psychiatric) placements.

Question. The end-of-year package that Congress passed in December included 1,000 new graduate medical education slots to address physician shortages across the country. The law directed HHS to focus new slots in rural and underserved areas, but left the Secretary with significant discretion in distributing slots.

What are the parameters that the administration will apply in distributing those slots?

Answer. HHS is working hard to implement new laws increasing medical residency positions in hospitals in rural and underserved communities to address workforce shortages. Encouraging more health professionals to work in rural hospitals and underserved areas, and the need to retain and train high-quality physicians to help address access to health care in these communities, is critically important.

In the fiscal year 2022 proposed rule (CMS–1752–P) for payment to inpatient and long-term care hospitals just released in April, CMS is proposing to implement provisions of the Consolidated Appropriations Act (CAA) that relate to Graduate Medical Education (GME). CMS is proposing to distribute the slots to qualifying hospitals, as specified by the law, including those located in rural areas and those serving areas with a shortage of health-care professionals.

Question. Nevada's Governor Sisolak signed into law legislation to create the Nation's second-ever public option after Washington State. That bill is the product of a lot of hard work by Nevada legislators and advocates, Nevada's new coverage option will be made available to people beginning in 2026, with implementation taking place in the interim. And my State will be seeking a Federal 1332 innovation waiver to enable us to provide more affordable coverage to Nevadans.

Can I get your commitment to work with me and my State on the successful implementation of this new law?

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. HHS is committed to working in partnership with States on policies that affect health insurance coverage in their States, including through applications for section 1332 State innovation waivers.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. As noted in the President's FY 2022 budget proposal, pharmacy DIR fees increased by more than 91,000 percent between 2010 and 2019. I continue to hear from pharmacists across Ohio about the challenges these fees create for small businesses and the patients they serve; the status quo is unsustainable for community pharmacies in Ohio and nationwide.

Recently, I partnered with Senators Tester, Lankford, and Capito to introduce bipartisan legislation to address this issue. Our legislation would increase transparency and create a standardized set of pharmacy performance/quality metrics to improve quality of care.

Does HHS have additional information on the increase in DIR fees that could help illuminate the changing trends in Medicare Part D? If so, please provide additional detail and any available data breaking down the yearly increase in DIR fees, includ-

ing the impact the increase in fees has had on community pharmacies and the patients they serve.

Will you commit to working with myself, and Senators Tester, Lankford, Capito, and others, to reform DIR in Medicare Part D by increasing transparency, establishing standardized quality metrics, and providing community pharmacies with more predictability so they can better serve Medicare beneficiaries?

Answer. Given the significant growth in pharmacy price concessions in recent years, when such amounts are not reflected in the negotiated price, it has become increasingly difficult for consumers to know at the point-of-sale what share, or approximate share, they are paying of the plan's costs for their prescription drugs. I look forward to working with Congress to improve transparency and competition in the Part D program.

Question. Pediatric patients are underrepresented in clinical trials and do not experience the same level of positive health outcomes associated with clinical research advancement. Among pediatric patients, the rate of clinical trial enrollment drops at the age of 15. Unsurprisingly, adolescents—with the lowest enrollment in cancer clinical trials—gain the least in terms of improvements to survival rates. Additionally, approximately 50 percent of all medicines used in children do not have FDA-approved labeling for pediatric patients. During clinical trials for COVID–19 vaccine candidates, trials in adolescent and pediatric populations enrolled participants less quickly displaying the lack of priority, investment, and infrastructure to conduct studies in this population.

The President's budget reflects strong investment in medical research—how will you ensure Americans of all ages are able to participate and therefore benefit from medical research and clinical trials?

Senator Wicker and I sent a letter to the National Institutes of Health in March 2021 requesting information and a meeting on this issue, and we have yet to receive a response. What specific steps will you take to ensure expanding access to clinical trials to underrepresented populations, including adolescents and children, remains a priority for this administration?

Answer. NIH received the letter from Senators Brown and Wicker and will respond soon. The information presented here also may be found in that response.

NIH is and remains committed to supporting clinical research that benefits individuals of all ages. Current plans to achieve that goal are focused on ensuring successful implementation of the NIH Inclusion Across the Lifespan Policy by engaging the scientific community; providing internal and external training, guidance, and communications; and ensuring NIH systems allow for collection and publication of data on participant age to help us better understand the distribution of participants in NIH clinical research.

NIH's Inclusion Across the Lifespan Policy[11] became effective in January 2019 and ensures that individuals are included in clinical research in a manner appropriate to the scientific question under study, so that the knowledge gained from NIH-funded research is applicable to all those affected by the researched diseases/conditions. The policy expanded the Inclusion of Children in Clinical Research Policy to require that all human subjects' research conducted or supported by the NIH includes individuals of all ages unless there are scientific, legal, regulatory, or ethical reasons to not include them. The policy also requires that the age of each participant at the time of enrollment be collected in progress reports.

In FY 2021, NIH began receiving data on participant age at enrollment for the applications submitted under the Inclusion Across the Lifespan Policy (for those applications submitted in 2019, awarded in FY 2020, and reporting progress in FY 2021). NIH continues efforts to enhance NIH systems to support submission, monitoring, and reporting of these data.

Several NIH-wide initiatives are working to identify opportunities for the inclusion of pediatric participants in research while prioritizing the most promising science. In September 2020, NIH held its second Inclusion Across the Lifespan Workshop[12] to examine the State of the science, discuss lessons learned, and share evidence-based practical advice to consider going forward. NIH issued a Request for Information to gather public input on potential topics for the workshop, which included discussions of inclusion and exclusion criteria; study design and metrics; re-

[11] *https://grants.nih.gov/policy/inclusion/lifespan.htm.*
[12] *https://www.nia.nih.gov/Inclusion-Across-Lifespan-2020.*

cruitment, enrollment, and retention; and data analysis and study interpretation. The full workshop report details are published on an NIH website [13] and summarized in the NIH Deputy Director for Extramural Research's "Open Mike" blog.[14]

The need to provide training and resources to researchers was among the common themes discussed at the Inclusion Across the Lifespan II workshop. In the fall of 2020, NIH held an NIH Virtual Seminar, with more than 13,000 attendees. The Seminar included several events focused on inclusion across the lifespan: a session on "Including Diverse Populations in NIH-funded Clinical Research;" an "Ask the NIH Inclusion Policy Officer" virtual discussion; a booth with resources for investigators on Human Subjects, Clinical Trials, and Inclusion; and opportunities for one-on-one discussions with NIH staff. NIH plans to host another NIH Virtual Seminar from November 1–4, 2021.

Question. Due to a decade of CMS oversight, hospital-based nursing schools across the country—10 of which are located in Ohio—are being made aware of overpayments they received up to a decade ago that they may be required to repay over the next year or so. Some have already been contacted to reopen closed cost reports to claw back Federal funds that were allocated and spent years ago. Hospital-based nursing schools are already in crisis as a result of the COVID–19 pandemic, and now they are being asked to repay the money they received due to no fault of their own. If left unaddressed, this could result in closure or scaling back of hospital-based nursing schools and other training programs leaving fewer nurses and educational opportunities.

Will you work with my office on solutions to help prevent these clawbacks and help preserve our hospital-based nursing schools through the public health and financial crisis brought on by the COVID–19 pandemic?

Answer. Encouraging more health professionals to work in hospital-based nursing schools and underserved areas, and the need to retain and train high-quality health professionals to help address access to health care in these communities, is critically important. These institutions are critical to our Nation's health-care system and have been especially important during the pandemic. I look forward to working with you on this important issue.

Question. I appreciate the President's FY 2022 commitment to maintaining funding for the Healthy Start program, which helps support community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk areas. Ohio is home to five healthy start sites, which have helped combat our State's significant infant mortality problem.

Are there lessons learned from the success of the Healthy Start program that could help inform strategies to address disparities in maternal mortality?

Answer. Healthy Start funding supports community-based interventions that address some of the most vulnerable populations of women, children, and families by providing a range of services associated with improving maternal and infant health outcomes. These services incorporate: (1) referrals and ongoing health-care coordination for well-woman, prenatal, postpartum, and well-child care; (2) case management and linkage to social services; (3) alcohol, tobacco, and other drug use counseling; (4) nutritional counseling and breastfeeding support; (5) perinatal depression screening and linkage to behavioral health services; (6) inter-conception education and reproductive life planning; and (7) child development education and parenting support.

In FY 2019, Healthy Start began supporting a new initiative to reduce maternal mortality through hiring of clinical service providers (*e.g.,* nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals) to provide clinical services, such as well-woman care and maternity care services, within program sites nationwide. In FYs 2020 and 2021, HRSA used $15 million to support these activities within existing Healthy Start grants. To date, 92 grantees have received clinician funding and hired 173 providers. Between November 2019 and October 2020, there were 18,540 visits at participating sites.

The FY 2022 budget request of $128.0 million continues to include $15 million to allow grantees to hire clinical service providers at Healthy Start sites to provide di-

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[13] *https://grants.nih.gov/sites/default/files/IAL-II-Workshop-Report.pdf.*

[14] *https://nexus.od.nih.gov/all/2020/12/10/some-thoughts-following-the-nih-inclusion-across-the-lifespan-2-workshop/.*

rect access to well woman care and maternity care services. In FY 2022, the program will continue to serve women and families across the Nation through the 101 grants awarded in the FY 2019 funding cycle. HHS looks forward to incorporating lessons learned as we continue to strategize on ways to achieve health equity and improve maternal health outcomes for racial and ethnic minorities.

Question. What specific actions is HHS taking to help strengthen coverage and access to high-quality, comprehensive care for pregnant and postpartum individuals to reduce infant mortality rates and address disparities in outcomes?

I have legislation—the Healthy MOM Act—that would establish a special enrollment period once an individual becomes pregnant. Would you work with me on ways to strengthen coverage options for pregnant women, including this idea?

Answer. Healthy Start programs have impacted families and communities across the United States through a reduction in infant mortality rates, increasing access to early prenatal care, and removing barriers to health-care access. Close collaboration with local, State, regional, and national partners is key to Healthy Start's success.

HHS recently approved multiple States' requests to test the effects of providing full Medicaid benefits to women for 12 months postpartum, significantly expanding coverage from the current 60-day postpartum period. Importantly, the American Rescue Plan provides an easier pathway for States to extend Medicaid postpartum coverage from 60 days to 12 months, and CMS expects to provide additional guidance to States on these provisions in the coming months. HHS also announced a Notice of Funding Opportunity (NOFO) that will make $12 million available over four years for the Rural Maternity and Obstetrics Management Strategies (RMOMS) program that will allow awardees to test models to address unmet needs for their target population. For the first time, applicants are required to focus on populations that have historically suffered from poorer health outcomes, health disparities, and other inequities.

I will continue to work tirelessly to reduce maternal and infant mortality and morbidity, using the expertise and resources across the many HHS agencies whose missions include ensuring maternal health. I am committed to working with Congress, and with State and local partners to make sure that we are improving maternal health; my team is happy to work with you on the Healthy MOM Act and other ways to strengthen coverage options for pregnant women.

Question. Thank you for your commitment to continuing efforts to address youth smoking and e-cigarettes, and for the FY 2022 budget proposal's commitment to preventing a new generation of children from becoming addicted to nicotine through e-cigarettes. I look forward to working with you to ensure this issue remains a top priority moving forward. As your budget acknowledges, e-cigarette use among youth increased by 78 percent among high school students and by 48 percent among middle school students from 2017 to 2018. While the 2020 National Youth Tobacco Survey showed a decline in youth e-cig use, youth use remains a public health crisis that demands urgent action. Given the fact that we do not yet have a confirmed Commissioner of the Food and Drug Administration, I ask for your commitment to ensure we do not fall behind on our efforts to address youth e-cig and tobacco use.

Can you please confirm that the FDA will meet the September 9, 2021 deadline to order the immediate removal of all deemed tobacco products, including electronic nicotine delivery system components or parts, that do not meet the criteria in 21 U.S.C. 387j to be appropriate for the protection of public health and have not received a tobacco product marketing order? What specific steps will you take to ensure the FDA meets this deadline?

Answer. All new tobacco products on the market without the statutorily required premarket authorization are marketed unlawfully and are subject to enforcement at FDA's discretion. FDA's highest enforcement priorities include products for which no application is pending, including (for example) those with a Marketing Denial Order and those for which no application was submitted.

As of June 10, 2021, FDA has received thousands of tobacco product submissions covering millions of tobacco products, the vast majority of which are for ENDS products. FDA has completed initial processing of all timely submitted PMTAs—more than 6.5 million products submitted by over 550 companies—and acceptance, filing, and substantive scientific review of the applications is underway.

Due to the large number of applications moving into review at the same time, the novelty of this review, the finite nature of our review resources, and the necessarily

rate-limiting effects of ensuring consistency across reviews, FDA developed a process to determine the review order for the applications. For PMTAs, the review order for most of the products is determined using a computer-generated randomization process. However, due to the large number of ENDS products currently marketed and for which we received applications, FDA decided to dedicate a portion of its resources to reviewing the products that account for the vast majority of the current market.

The continued marketing of these widely used products has the potential to have the greatest public health impact—either positively or negatively—as they hold the largest overall market share and therefore are likely used by the largest number of people. For this reason, FDA pulled several applications into a separate review queue and dedicated resources to their review. By identifying and ensuring review of these applications, we believe we can achieve the greatest public health impact most quickly. If FDA finds that a currently marketed product is not appropriate for the protection of public health—the standard in the law for marketing a new tobacco product that is the subject of a PMTA—the agency will issue a No Marketing Order (NMO) and the product must be removed from the market. Conversely, if FDA finds that a currently marketed product does meet the standard in the law for marketing, the agency will grant a marketing order and the product may remain on the market subject to the conditions in the order. In either case, earlier review of a currently marketed product ensures a faster transition to a marketplace of products that have been scientifically reviewed for their impact on public health.

We are working to review applications as quickly as possible. However, given the unprecedented number of applications and other factors discussed above, reviewing all the applications by September 9, 2021, will be challenging. We will continue to allocate our resources with the goal of working as quickly as possible to transition the current marketplace for deemed products to one in which all new tobacco products available for sale have undergone a careful, science-based review by FDA. We will focus resources on products where scientific review will have the greatest public health impact, including with respect to youth use of ENDS products, based on their market share, while also reviewing as many applications as possible from all companies regardless of size, prior to September 9, 2021, at which time they risk FDA enforcement.

FDA has commenced substantive scientific review on over a thousand products submitted through the PMTA pathway. The agency continues to review tobacco product applications through all applicable premarket pathways and provide updates on its progress through FDA's *Tobacco Product Applications: Metrics and Reporting* webpage.

Question. Will you commit to applying the appropriate for the protection of the public health (APPH) standard for all new tobacco products to ensure that *no* marketing orders are issued for any product—including any liquid, solution, or other component part—that contains a flavor unless the manufacturer has demonstrated that the characterizing flavor: will increase the likelihood of smoking cessation among current users of tobacco products; will not increase the likelihood of youth initiation of nicotine or tobacco products; and will not increase the likelihood of harm to the person using the characterizing flavor?

Answer. Yes, I assure you that FDA will commit to applying the appropriate standard for the public health standard.

Question. On April 29, 2021, the FDA announced that it would commit to advancing a tobacco product standard to ban menthol as a characterizing flavor in cigarettes. This step is long overdue.

Will you ensure the FDA moves forward quickly to finalize rulemaking to set product standards that ban menthol in cigarettes and cigars in order to protect public health and address racial and ethnic health disparities?

Answer. On April 29, 2021, FDA announced its commitment to issue two tobacco product standards: one to prohibit all characterizing flavors, including menthol, in cigars; and a second to prohibit menthol as a characterizing flavor in cigarettes. FDA aims to and remains on track to issue both proposed rules by the end of April 2022.

Question. As you know, the CDC is currently working to update and replace two NIOSH facilities in Cincinnati, OH. On May 12, 2021 the CDC and GSA presented its schematic design for the new campus to local stakeholders in Cincinnati; the pro-

posal was met with a lot of enthusiasm from the local community and interested parties are eager for the project to move forward.

This project is not just about updating the NIOSH buildings—this is about improving government efficiency and creating jobs in Southwest Ohio. Last year you committed to continuing to move this project forward. I again ask for your commitment to making this project a priority for the administration and keeping this project on schedule, despite the FY 2021 budget's proposed cuts to CDC.

Question. Has the CDC finalized its purchase of the properties necessary to move forward with this project? If not, please provide an update on the purchase timeline.

Answer. At this time, CDC has completed due diligence efforts such as environmental assessments, appraisals, title searches, boundary surveys, and cost negotiations. In addition, CDC has submitted necessary title evidence to the Department of Justice (DOJ). Once an acceptable preliminary title opinion is received from DOJ, CDC will immediately move forward with formal closing on the property. The estimated closing for the University of Cincinnati Foundation Holdings owned parcels is August 2021 with the City of Cincinnati owned parcels expected to close in December 2021.

Question. Please share an update on the timeline for the NIOSH site consolidation and construction project in Cincinnati, Ohio. Do you expect the completion of construction and occupancy of the facility by NIOSH staff to take place by Summer 2024?

Answer. The architectural and engineering design is well underway with an anticipated completion in December 2021. CDC will move forward with the Construction phase in Summer 2022 with an anticipated occupancy date of Fall 2024.

Question. I understand that the CDC anticipates awarding a contract for the project to a General Contractor in late 2021. Please elaborate on the resources HHS plans to spend on this project in FY22 to ensure it continues to move forward according to plan.

Answer. Due to the extended property acquisition schedule identified in the response above, CDC anticipates the award of the construction phase in Summer 2022. In addition, CDC has assigned senior-level staff to this project to ensure it continues on-schedule to be completed in Fall 2024.

Question. Will you commit to working with Senator Portman and me to keep this project moving forward under your leadership at HHS?

Answer. CDC remains committed to construction and development of the Consolidated Cincinnati Research Facility. As the project continues to accelerate, HHS is committed to working with you and Sen. Portman to keep this project moving forward.

TB was the world's most deadly infectious disease until November 2020, now second only to COVID–19, and still ranking ahead of HIV/AIDS, killing 1.4 million people annually. In the United States, TB remains a serious problem with all 50 States continuing to report cases annually. According to CDC, there were an estimated 7,163 new cases of TB reported in the United States during 2020. The pandemic severely impacted TB case notifications due to TB program staff being reassigned to work on COVID–19 and patients being unable or unwilling to seek testing and care under stay-at-home orders and similar policies.

The President's FY 2022 budget proposal states that the "CDC envisions a future free of . . . tuberculosis."

Question. How will the proposed increase in funding for the CDC's HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infection and Tuberculosis Prevention program help move us closer to the stated goal of eliminating TB, and ensure the CDC is able to continue to make progress toward eliminating TB in America?

Answer. CDC's domestic TB program drives TB elimination strategy in the United States and globally. State, local, and international TB programs depend on CDC for innovations that bring us closer to TB elimination.

Through CDC's Tuberculosis Trials Consortium (TBTC), CDC supports vital, unparalleled epidemiologic research and clinical trials that have significantly impacted TB treatment. In FY 2022, CDC's newly recompeted TBTC will continue to focus on improving treatment for TB disease, particularly among children and people living with HIV/AIDS.

Additionally, in FY 2022 CDC will continue to support 50 States, eight large cities, Washington, DC, and two territories to conduct TB surveillance and oversee the medical and public health management of persons with TB and their contacts. CDC will also continue to fund four TB Centers of Excellence to provide training and technical assistance for contact tracing, outreach, and case management, TB educational materials, and medical consultation for health-care professionals treating TB patients, particularly those with complex or drug-resistant cases. CDC will offer state-of-the-art TB laboratory services to health departments, free of charge. To expand targeted testing and treatment for LTBI, CDC will continue to work with health departments, professional associations, and other groups to explore ways to test people who are currently unable to receive preventive TB services through health departments.

Question. What are the CDC's plans to prioritize its global TB efforts and sustain partner countries' efforts in addressing TB globally?

Answer. CDC is on the frontlines in more than 25 countries working with partner governments to find, cure, and prevent TB and sustain and enhance global public health systems; CDC is also working with partners to improve case-finding approaches and optimize use of diagnostics. CDC collaborates with countries and the World Health Organization (WHO) to conduct TB prevalence and drug resistance surveys to document the global burden of disease. Data from these surveys allows countries to target health interventions. CDC also focuses on optimizing TB and multidrug-resistant TB treatment regimens, improving linkages to care and treatment, improving treatment adherence and cure rates among patients with drug-resistant TB, and assessing costs and barriers to care. CDC is also scaling up laboratory external quality assurance systems and training, strengthening surveillance systems to improve TB and MDR–TB burden estimates, improving track program performance, and training ministry of health and national TB program staff. Additionally, CDC provides laboratory technical assistance to partner countries through the agency's Reference Lab to ensure the efficiency of diagnostic networks and accuracy of laboratory and point of care testing. Working in tandem with PEPFAR, CDC supports TB screening for people living with HIV and leads in the PEPFAR effort to ensure people living with HIV have access to latent TB treatment, significantly reducing the chance they will become ill with TB.

Question. Under current law, Medicare covers short-term, inpatient, respite care services for hospice patients if their primary caregiver needs a break. Medicare will cover up to 5 days of respite care if the hospice beneficiary's primary caregiver is ill, needs rest, or is otherwise unable to care for the hospice patient at that time. However, respite care may only be provided in an inpatient facility, such as a hospital, hospice facility, or nursing home, and the benefit is limited to just five days at a time.

The existing limitations on Medicare's hospice respite benefit have made it difficult for family caregivers to utilize this important benefit during the COVID–19 pandemic. Some families are reluctant to utilize the respite benefit because doing so would mean moving their loved one into a congregate living facility—such as a hospital or nursing home—where there may be a greater risk of contracting the virus. Additionally, some caregivers may need more than 5 days of respite care if they believe they have been exposed to COVID–19 and need to isolate for 2 weeks. COVID–19 has demonstrated to us the importance of providing hospice patients and families much needed respite care in various settings, including in their communities and homes or wherever they may call home.

Senator Capito and I have introduced the COVID–19 Hospice Respite Relief Act to strengthen Medicare respite care for some of our most vulnerable Americans. Our legislation would allow the Secretary of HHS to make the hospice respite care benefit more flexible during any public health emergency, helping to meet the needs of both hospice patients and their caregivers by: increasing the number of days a patient can receive respite care from 5 days to 15 days; and making the hospice respite benefit available to hospice patients in their place of residence as an alternative to an inpatient setting.

While I understand that there may be existing flexibility under hospice's routine home care benefit to provide respite care in the home, I have heard concerns from community providers that the routine homecare rate may not be sufficient to cover the care necessary to truly provide respite care. In addition, patients are capped at 5 days of care.

Will you work with Senator Capito and I to ensure access to meaningful respite care for all those who need it by exploring existing regulatory authority options and by working with us on legislative solutions, if necessary?

Answer. Building on lessons learned during COVID–19, I look forward to working with you to make sure hospice patients and their caregivers can receive respite care services. As someone whose father passed away at home, ensuring that patient choices are respected, including the ability to receive care at home, is of utmost importance.

Question. Section 108 of the No Surprises Act, which passed into law as part of H.R. 133, the Consolidated Appropriations Act of 2021, contains a provision that requires HHS, along with the Departments of Labor and Treasury, to promulgate rules on provider nondiscrimination. My office has heard from stakeholders who are anxious to see this section of law implemented.

Recognizing that this rulemaking may be a joint effort between HHS, DOL, and Treasury, please provide a proposed timeline for implementation of section 108.

Will HHS, DOL, or Treasury be taking the lead on this rulemaking? Please provide an update on any efforts already underway at HHS to promulgate this rulemaking.

Will you commit to finalizing the rule under this section this year?

Answer. HHS is working collaboratively with the Departments of Labor and the Treasury to ensure that the No Surprises Act, including section 108, is implemented in a timely and effective manner.

Question. As you know, States are set to implement services under the Family First Act by October 1st of this year.

Please describe how the Department's FY 2022 budget will ensure States, including county-administered child welfare systems like Ohio, can effectively implement the law?

Answer. Two of the important provisions of the Family First Prevention Services Act (FFPSA) (as part of Public Law 115–123) were provisions placing limitations on title IV–E foster care payments for children placed in non-family-based foster care settings (*i.e.,* child care institutions) and the creation of the title IV–E Prevention Services Program. FFPSA allowed a title IV–E agency to request a delay of up to 2 years (until October 1, 2021) for the provisions of the law limiting Federal financial participation for placements that are not in foster family homes. Title IV–E agencies choosing to take a delay in the provisions relating to foster care were required to delay participation in the title IV–E Prevention Services for the same period. Ten States and five tribes chose not to delay implementation of these provisions. Most title IV–E agencies (36 of 53 States and territories operating title IV–E, and six of 11 tribes directly operating the title IV–E program) chose to take the maximum delay of 2 years to implement these provisions. The remaining 7 States requested to delay for a period of less than 2 years. While participation in the title IV–E Prevention Services Program is optional, many States and tribes are actively working toward implementation. To date, 34 States, the District of Columbia, and four tribal jurisdictions have submitted Prevention Plans. Of those, 17 State plans (Utah, Maine, Maryland, Arkansas, Kansas, Kentucky, North Dakota, West Virginia, Virginia, Washington, Nebraska, Iowa, Ohio, Oklahoma, Oregon, Hawaii, and Illinois), the District of Columbia plan, and one tribal IV–E plan (Eastern Band of Cherokee Indians (North Carolina)) have received approval.

The HHS FY 2022 budget provides increased resources to support the capacity of the title IV–E Prevention Services Clearinghouse to conduct its reviews of prevention programs, as well as technical assistance and evaluation activities to expand the availability of rated programs and practices for the title IV–E Prevention Services Program.

On behalf of the Children's Bureau, the Capacity Building Center for States (the Center) assists State and territorial child welfare agencies, including those that have county-administered systems, build capacity to better serve youth and families by undertaking training and technical assistance activities and promoting best practices in child welfare such as those related to implementation of the requirements of the Family First Prevention Services Act. The Child Welfare Information Gateway (Information Gateway) develops, disseminates, and maintains publications, website pages, general information, and guidance on a variety of child welfare topics, including those supporting implementation of the requirements of the FFPSA.

The Center provides customized support to jurisdictions in developing more prevention-oriented systems and leveraging the transformational opportunities in the FFPSA to right-size residential care, address race equity in child welfare, explore and implement evidence-based programs, and shift resources to better support healthy families. In collaboration with the State (and counties as appropriate) and the Children's Bureau, the Center assists States in implementing FFPSA.

In addition to providing direct services to jurisdictions, the Center facilitates peer-to-peer connections via peer groups. Two groups, Transformational Child Welfare Leaders and Family First Prevention Plan Leads directly support implementing FFPSA and moving toward a prevention-oriented system. An additional peer group, County-Administered State Partnership Peer Group, promotes collaboration and problem solving among peers from county-administered State child welfare programs.

Finally, Information Gateway and the Center develop tools, resources, and products to build knowledge and support practice and have prioritized publications supporting implementation of FFPSA. Information Gateway is currently developing a web section to provide information related to FFPSA.

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

Thank you, Mr. Chairman. The events of the past year have emphasized the importance of the Department of Health and Human Services.

Last year, the efforts of HHS and its sub-agencies ensured safe access to crucial health-care services, even at the height of the pandemic, through telehealth expansion and other emergency flexibilities. HHS also proved pivotal in partnering with private-sector innovators to help bring several safe and effective COVID–19 vaccines to the public in record time.

In the months ahead, the administration should work with Congress to build on these successes, as well as to address some of the challenges the past year has created or exacerbated. Certain aspects of the President's budget request seem aligned with these aims. The proposal describes a concerted effort to build on our program integrity efforts to tackle waste, fraud, and abuse, which harm taxpayers, patients, and families. Program integrity represents a clear area of common ground.

The budget request also highlights the importance of value-based care, which will prove indispensable as we work to lower health-care costs while increasing care quality. Unfortunately, other aspects of the President's proposal raise serious questions and concerns.

Medicare trust fund solvency remains a pressing crisis, jeopardizing benefits for tens of millions of seniors, and yet this budget request proposes no meaningful policies to contain unsustainable spending growth. In fact, apart from outlining trillions of dollars in tax increases and spending hikes, the budget proposal offers few policy details at all. Much of the blueprint focuses on vague references to agenda items, with no meaningful discussion of how to pay for them.

These policies stray substantially from the promise of unity and bipartisanship initially advertised by this administration. Proposals to lower the Medicare eligibility age, for example, would likely crowd out private coverage without moving the needle on access or affordability—all on the American taxpayer's dime. The budget request also suggests using Medicare dollars to expand Obamacare, just as we saw with the original passage of the ACA more than a decade ago.

Rather than champion the market-based reforms that have made Medicare Advantage and Part D such resounding success stories for our Nation's seniors, the budget proposes a convoluted price control scheme for prescription drugs that would reduce access to lifesaving cures in the years ahead. For the roughly four in 10 seniors enrolled in Medicare Advantage plans, the policies referenced in the budget request could also mean drastic cuts, which could jeopardize supplemental benefits like dental and vision. The document also affirms prioritization of $400 billion to increase access to home and community-based services.

Home and community-based services are a key lifeline for scores of Americans, and Congress should consider bipartisan policies to expand availability. This should include ensuring States have the workforce necessary to meet demand.

Unfortunately, media reports suggest this $400 billion may be used to establish certain labor reforms that fail to address the gaps in patient services States have experienced for decades. That being said, I am confident we can find areas of common ground, and I look forward to working with you, Mr. Chairman, to advance consensus-driven policies on a range of health-care issues, from telehealth to value-based care.

Mr. Secretary, it is good to see you again. I look forward to your testimony and to discussing these and other vitally important issues with you today.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This morning the Finance Committee welcomes Secretary Becerra to discuss the president's 2022 budget proposal for the Department of Health and Human Services. There's a lot to talk about this morning. I'm going to begin with out-of-control drug prices.

Far too many Americans are getting clobbered with every trip to pick up their medications at the pharmacy window. The latest drug pricing news is the approval of Aduhelm, a new medication for Alzheimer's disease—one of the chronic diseases that now define Medicare in the modern day. The drug's approval was controversial. There is little data showing it actually does what the company says it will do. Despite that, Aduhelm has an unconscionable list price of $56,000 per year. Let's understand, it is not a cure, like some other recent breakthrough drugs have been. Patients could be on Aduhelm for years at a time after their diagnosis, multiplying the overall cost of treatment.

Setting aside the lack of clear evidence that this new Alzheimer's drug actually works, medical science today is capable of miracles. The speedy development of highly effective coronavirus vaccines is one example. Everybody in this room welcomes and cheers those advances. However, Americans are terrified by the status quo on drug pricing. Not only are too many Americans forgoing or rationing their prescriptions, sky-high drug prices could bust our health-care budgets.

I'm working to update the Finance Committee's prescription drug legislation from the last Congress, and I welcome the ideas of all members of the committee. I believe it's long past time to give Medicare the authority to negotiate better prices for prescription drugs on behalf of more than 50 million seniors. Overwhelmingly, the American people support that idea. President Biden, during his joint session speech in April, called on the Congress to get it done.

We are all hungry for genuine medical breakthroughs, but what does it mean, Senators, if the vast majority of Americans cannot afford them?

A few other issues related to the budget proposal and the administration's HHS priorities. It's very welcome to see proposals on mental health, because mental health care is a major priority for this committee. We'll have a lot more to say on mental health during our Finance Committee hearing on the topic next week.

As I've discussed with Secretary Becerra, I look forward to continuing to work with his team on further implementation of the CHRONIC Care Act, specifically expanding its benefits to those receiving traditional Medicare. That way, the law Congress passed back in 2018 will continue to update the Medicare guarantee.

I'm also pleased that the administration is going to continue making progress on the issue of transparency and sunlight with respect to health-care prices. It's important to make sure that progress is useful to consumers as part of an overall effort to make health care more affordable.

The budget includes a proposal for a landmark investment of $400 billion to expand access to home and community-based services through Medicaid. This would be an absolute game-changer resulting in more choices and better care for millions of seniors and people with disabilities.

Senator Casey and I, along with a lot of other members on this committee, are working nights and weekends to get this done. We're also interested in building up the care workforce to make sure these changes deliver on their huge potential.

On the subject of helping the most vulnerable Americans out there, I'll close on child welfare. A few years ago this committee passed legislation called the Family First Act to help more families stay together safely instead of relying on foster care.

One of our key goals was to get more help to black and Native American families, whose kids are disproportionately represented in the child welfare system. However, the Trump administration gave short shrift to the implementation of this law, and it is not living up to its promise for a lot of those vulnerable youngsters.

The Biden administration has an opportunity to change that. It is also proposing a new grant program that ought to help address racial disparities in the foster care system. I'm looking forward to working with Secretary Becerra on these issues. There are a lot of kids and families who will benefit from it.

COMMUNICATION

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Statement of Michael G. Bindner

Chairman Wyden and Ranking Member Crapo, thank you for the opportunity to submit these comments for the record on the HHS FY 2022 Budget Request. We address the funding of the Affordable Care Act, the need for an immediate COLA for retirees, funding the Social Security Administration's non-fund costs and the idea of cost savings for Social Security.

So far, the Administration has not yet addressed changes to the Affordable Care Act, at least not publicly. We suggest that the Committee ask the Secretary about any such plans.

At minimum, the individual and employer mandates, with associated penalties, that were repealed must be restored. The President campaigned on restoring and perfecting the Act, adding a public option. We agree, although the public option need not be self supporting. It must be subsidized through a broad based consumption tax. Such a tax burdens both capital and wage income.

The current funding stream seems to have been designed to draw opposition from wealthier taxpayers. It is an open secret that the Minority does not oppose most of the Affordable Care Act (which was designed by their own Heritage Foundation as an alternative to Mrs. Clinton's proposals). Broaden the tax base to fund the program and the nonsense on repeal will end.

The current funding stream from student loan initiation and interest, which was included in the baseline, should also be ended. Graduates (and non-graduates) with student loan debt cannot afford both their loan payments and insurance payments under the Affordable Care Act. When they apply for lower loan payments, which are always granted, they face either a balloon interest payment or capitalized interest, which makes their funding situation worse. No one should have to retire with student load debt, yet quite a few soon will (or already have).

Forgive capitalized interest and apply any overpayments to principal. There should not be a one-size-fits-all subsidy. Also, when payments are deferred, return to the practice of deferring interest (or allow debts to be discharged, at least partially, in bankruptcy).

To deal with these issues, whatever is budgeted for analytical support in the Department should likely be doubled.

The following analysis comes from the Single Payer attachment that has previously been provided. Because of the President's preference for establishing the public option, we will repeat those analyses here. Aside from a broader base of funding, other compromises are necessary to enact a public option.

To set up a public option and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs when insurance companies are bailed out in bankruptcy, the public option covers everyone and insurance companies are limited to administering the government program on a state by state basis.

The financing of the Affordable Care Act should be broadened. It should neither be funded by the wealthy or by loan sharking student loan debtors. Instead, it should be funded by an employer-paid consumption tax, with partial offsets to tax payments for employer provided insurance and taxes actually collected funding a Public Option (which should also replace Medicaid for non-retirees). Medicaid for retirees and Medicare should be funded by a border adjustable goods and services tax, which should be broad based.

Why the difference? The goal is to not need a public option as employers do the right thing and cover every worker or potential worker. Using an employer based tax is an incentive to maximize employee coverage. Medicare, however, is an obligation on society as a whole.

Our comments on Social Security administrative and capital costs originated in our testimony to the Appropriations Subcommittee.

I submitted our testimony as an SSDI beneficiary, as well as for retirees. Even before the pandemic, my SSDI was inadequate for food, medicine, clothing and cable. If I owned a vehicle, there is no way I could maintain it or even buy gas. I have an above average benefit, high enough to be ineligible for SNAP or Medicaid. Many are not so lucky, even on a good day.

In the last few months, days have not been so good. Were it not for stimulus payments, I would be running out of food as I write this and would not have just bought new clothes, from socks and underwear to a jacket I can wear when the Committee finally asks me to testify in person. As it is, I will need to use the last $600 from my December payment (which should have come through Social Security) to attend my upcoming high school reunion. Whale I have wifi, I cannot afford cable and a car is still out of reach.

Let me underline a point. In most months, new underwear is not an option, I rely on free bus rides due to the pandemic and subsidies from Ride On and there is never enough money in that last week before the check comes. When it does arrive, the cupboard is bare.

Food prices are skyrocketing. Part of the problem may be too much money chasing too few goods, but retirees and the disabled find (our)selves between a rock and a hard place. We need a COLA and we need it now. Most of us cannot even afford cola. Because this is a short term emergency due to the Pandemic, it should be funded out of the general fund until the normal process kicks in for next year.

This brings us to the funding of Social Security administrative costs. They are low—the most efficient in retirement savings. However, they should not have any. This is especially the case responding to the pandemic.

Use general revenues now to fund administration, improvements and more office space. As the pandemic wanes, caution will still be necessary for a while. It is time to build out some infrastructure in both government and leased space. The same is the case for Medicare and Disability Insurance costs.

The general fund already owes trillions of dollars to the Social Security Trust Fund. Rather than trying to figure out how to extend the fund for a 75 year balance at the expense of future retirees, fund n0n-benefit costs immediately from the general fund.

State governments are under financial pressure as a result of the pandemic, especially in the area of healthcare costs, most especially for seniors in nursing homes who are “dual eligibles.” The heart of President Reagan’s Federalism Proposal was the transfer of state Medicaid expenses to the federal government, largely to fund baby boomers who would become dual eligible with time. Time is now up, or will be shortly.

Welfare has been reformed, allowing state and federal governments to save money—which was part of the New Federalism bargain that was not accepted at the time.

We will address this part shortly, but the irony is that federal money was reduced without the second part of the trade-off.

Finish the process and create Medicare Part E for low income disabled and retirees. This will put investigation of nursing home conditions into the federal sector. States have done a poor job in enforcement of health and safety standards. It is time to make this a national responsibility.

One way to increase benefits generally is to increase the minimum wage, the higher the better, and rebase current benefits to consider such an increase to be wage inflation. Such a change will fund itself, because wages funding benefits will be increased across the board.

For long term balance, any cuts must be avoided. Indeed, they are dead on arrival. In the long-term, as we have stated recently as well, debt will be a problem—but not within the next few years—as neither Europe nor China will enact the same kind of consolidated income tax, debt and monetary reserve system that allows us to be the world's currency securitization provider.

Debt reduction must not be an excuse to cut entitlements. As we state in our debt volume, Squaring and Setting Accounts: Who Really Owns the National Debt? Who Owes It?—December 2019, the debt assets owed to the bottom 40% are sacrosanct, as they paid for it with regressive payroll taxes while they were working or by having to shift from the Civil Service Retirement System to the Federal Employee Retirement System which required savings rather than a defined benefit.

Forty years ago, the decision was made to advance-fund the retirement of the baby boomers, rather than immediately begin subsidies from the general fund. Doing so would have required repealing the tax cuts for the rich enacted by President Reagan, the Senate and just enough conservative Democrats in the House to do damage.

Now that the wealthy have to pay what they owe to the trust fund (or rather, the children of the wealthy of the 80s), people are talking about means-testing Social Security and were talking about making it attractive to upper classes by investing it. The latter nonsense died in 2008. The former would again make asset holders fix the debt liability of the top 10%. It would also rob the bottom two quintiles of their most effective voice—higher income taxpayers who do receive benefits. As long as they get them, the program is safe.

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