Hearing Transcript

House Energy and Commerce Subcommittee on Health Hearing on President Obama's Fiscal 2017 Budget Request for Health and Human Services

February 24, 2016

PITTS:

The subcommittee will come to order. This is a pretty busy day. A lot of members will be here today, so we'll have to run a tight gavel, so everyone can get an opportunity to speak today.

The chair will recognize himself for an opening statement. Today, the Health Subcommittee will examine the president's budget for fiscal year 2017 for the Department of Health and Human Services.

We're grateful the secretary has agreed to appear before this subcommittee, and certainly there are a number of issues in the budget and at HHS that members will be interested in discussing. I appreciate the strong bipartisan record this committee has in working with Secretary Burwell, especially our work to solve the Medicare physician payment issue last year. Our committee has passed more bipartisan bills into law than any other committee in Congress, and we appreciate Secretary Burwell's partnership to help make that possible.

However, as I reviewed the budget, I have to say I am disappointed. This budget does not balance, ever. The CBO warned that under current law the deficit will balloon from $616 billion this year to $1.4 trillion by 2026. Medicare, of course, is on course to be insolvent and unworkable in the year 2026. Federal debt will soar from $14 trillion this year to about $24 trillion by 2026.

Economists warn us that our runaway federal health spending will eventually lead to an economic crisis, drastic and disruptive cuts, higher taxes that harm workers and families, or some combination of all of these outcomes. I believe Congress and the administration have a moral responsibility and duty to solve the problems before they fail the millions of people who depend on them.

Unfortunately, our long-term spending challenges have been worsened by changes to federal programs in recent years, specifically Obamacare's over $2 trillion in new entitlement spending. Yesterday's Washington Post highlighted a new report from the HHS Office of Inspector General, which examined HHS's mismanagement of HealthCare.gov. And as the report makes clear, there was more that failed beyond just a website.

The OIG concluded, quote, "We found that HHS and CMS made many missteps throughout development and implementation that led to the poor launch. Most critical was the absence of clear leadership, which caused delays in decision-making, lack of clarity in project tasks, and the inability of CMS to recognize the magnitude of problems as the project deteriorated. CMS's organizational structure and culture also hampered progress," end quote.

Today, a new report out from the GAO has new findings regarding mismanagement of the federal marketplace. The auditors find CMS is, quote, "passive," end quote, in their approach to fraud prevention and has failed to resolve major inconsistencies in applications in 2014 and 2015. Because of re-enrollments and CMS's poor oversight, these problems are largely still ongoing.

And time and time again, HHS seems to be ignoring or flouting the law. For example, one issue I continue to be concerned about is the matter of illegal actions taken by the California Health Department with respect to their unilateral action requiring all health plans to cover abortions. This is in direct violation of federal law under the Weldon amendment and a direct assault on conscience rights.

As you know, individuals have been harmed since August 22, 2014, and filed complaints with the HHS Office of Civil Rights. And I have pleaded with you, Madam Secretary, to give this matter your immediate attention and redress. To my knowledge, no action or redress has been taken by your agency. So we hope and expect to receive real answers today.

So, Madam Secretary, thank you for being here. We look forward to your testimony. I yield the remainder of my time to Mr. Burgess. Mr. Burgess?

BURGESS:

Thank you, Mr. Chairman, and, Secretary, welcome. And thank you for coming to our subcommittee.

Look, the president and I are never going to agree on the Affordable Care Act. But I do remain committed to making real improvements to health care right now for the American people. Unfortunately, the administration has persistently refused to acknowledge the failures within the Affordable Care Act, making it near impossible for Congress to reduce harm to people going forward.

The chairman already outlined the statements in the Office of Inspector General's report that recently became public. I hope that the agency will share with us the lessons learned from this exercise. Clearly, there will be other administrations, there will be other people in charge of the agency in the future, and the lessons learned from the failures at HealthCare.gov I think are important.

I would like for you to share with us what the total cost of the website was. The published figure of $830 million, I believe, is way too low. I would like for you to share with us what the actual cost was. Were you able to recoup any of the costs from the product that was not delivered? And was anybody paid a performance bonus for actually supplying a flawed product to the American people?

I think these are questions that ongoing need to be answered. We need to know what lessons your agency has learned from this process.

Thank you, Mr. Chairman. I'll yield back.

PITTS:

The chair thanks the gentleman. Now standing in for Ranking Member Green is Representative Castor of Florida. The chair recognizes her for five minutes for an opening statement.

CASTOR:

Well, thank you, Mr. Chairman. And good morning, Madam Secretary.

You and the administration have crafted a budget that works for American families. It strengthens Medicare, extends the life of the hospital task force, Medicare Part A, for 15 years, makes vital investments in cancer research, Alzheimer's research, and in the NIH, and keeps those fabulous researchers across the country on the job, finding the treatments and cures of the future.

I want to thank you for answering the call for help from communities and families across the country with more robust resources for mental health care and for the heroin, prescription drug, opioid epidemic. And you've done this at the same time while the overall budget reduces deficits by $2.9 trillion over the next 10 years, and that's on top of the $4 trillion to $5 trillion deficit reduction that we've achieved together since 2010.

I'd like to encourage you during your testimony to discuss the progress of states that are taking care of their citizens through the expansion of health services under Medicaid. This is smart fiscal policy. And the majority of states have realized that. But it is difficult to reconcile that we have the majority of states that have done it and then some states that have not, including my home state of Florida, because that puts my citizens at a disadvantage.

So I want to thank you for offering hope to those citizens in those states that have yet to expand Medicaid. And back to mental health, this is directly related to our ability to serve our neighbors with mental health services, because the most important reform we can bring to communities for mental health would be expansion of Medicaid in those states.

But on your watch, for the first time ever, more than 90 percent of Americans have health coverage, including 1.7 million in Florida this year on HealthCare.gov. The Medicare Advantage premium has declined since the ACA became law. In Florida, $1.3 trillion is being put back into the pockets of my neighbors through closing the donut hole under the ACA. And the growth in premiums for employer-sponsored health insurance has slowed down.

But we have more work to do, and we'll look forward to hearing your testimony. And at this time, I yield a minute to my good friend, Mr. Kennedy of Massachusetts.

KENNEDY:

Thank you, Congresswoman, for yielding. And, Madam Secretary, thank you for coming. It's wonderful to see you again.

Under your leadership, the Department of Health and Human Services confronts some of our nation's most stubborn and systemic challenges head on. With the reforms to Medicaid outlined in the president's budget, we can enroll millions of vulnerable Americans who remain uninsured and risk losing a lifetime of savings due to a hospital bill.

Expanding access to Medicaid is especially critical because of the program's beneficiaries are twice as likely to face mental illness than the general population. But we can't limit our response to those enrolled in Medicaid. We had an increase of $115 million for the mental health programs under SAMHSA, investments in community early intervention programs, and an end to the 190-day lifetime limit on inpatient psychiatric facilities. We can ensure millions of Americans receive the treatment they need and deserve.

And in the midst of an opioid epidemic that has had a devastating impact on the communities represented by everyone on this dais today, your request for $1 billion to increase access and treatment should be quickly considered and approved by Congress. I also want to thank you and recognize your commitment to community health centers that make a -- where the budget makes a sizable investment. And also, thank you and your staff for continuing to speak with our governor as we work on a Medicaid waiver negotiations and our hospital system.

Looking forward to hearing you talk about more of these projects in some detail and ask you to let us know how we can be a partner in your work ahead. Thank you, and I yield back.

PITTS:

The chair thanks the gentlelady and now recognizes the chairman of the committee, Mr. Upton, five minutes for an opening statement.

UPTON:

Well, thank you, Mr. Chairman.

Secretary Burwell, welcome back to the committee. And although we do have policy differences, I appreciate the professionalism that you have brought to the job from day. It's most appreciated.

And I know that you were in Michigan last week regarding the tragic Flint water crisis. I appreciated the call last Friday when you were leaving, and I thank you for your attention and look forward to closely working together to ensure that we make it up to the residents of Flint for the many unacceptable failures that have occurred at all levels. And I really appreciate that.

We've also enjoyed our partnership in the 21st Century Cures. You and your team have been terrific during this two-year effort, working closely and providing valuable insight, technical assistance and guidance as we developed a bill that achieved 344 votes in the House.

The momentum is building as the Senate now has taken real and bipartisan steps forward through their parallel Innovation project. With a little more hard work, bipartisan cooperation, we're going to be able to get this done for patients across the country looking for hope for safer cures.

And we were excited with President Obama tasking Vice President Biden to lead a moonshot effort to cure cancer. And I know that you're a part of that leadership team. Surely it will bring a jolt of energy for this very important project, the goals of which are consistent with the bill passed by the House last summer. It's important to remember that time is of a very precious resource, especially for countless patients across the country who can't wait for another task force. The clock is ticking. They need action. And they need cures now.

It's my belief, as shared by Chairman Alexander, that the way for policy to be enacted through the 21st Century Cures Act and the Senate's Innovation project is by working together. We've done the hard, time-consuming work of listening, soliciting ideas, listening some more. The legwork is done, and as I mentioned, with 344 votes in the House, the policies have been pressure tested.

We look forward to combining our efforts and the vice president's best ideas into one unified bill to improve our health care innovation ecosystem. We've got an incredible opportunity that we know that we have to deliver.

This hearing also gives us an opportunity to discuss the important work of putting our fiscal house in order. An astounding $1 trillion now flows through HHS. We have significant concerns that our budgetary path is on a dangerous trajectory towards disaster. Under this president's budget, the national debt will more than double than when the president took office. The projections cannot be ignored, especially as health and entitlement spending will be the main factor in driving additional debt on top of future generations. We can and must do better.

And I yield the balance of my time to Ms. Blackburn.

BLACKBURN:

Thank you, Mr. Chairman.

And, Madam Secretary, we do thank you for being here. There are a couple of things that I'll want to hit and hear from you as you talk today. First of all, I think HHS needs to look at a regulatory model that is going to enable innovators. Many of those innovators in health care informatics are in Tennessee. And what they find many times is lack of certainty and clarity.

So let's discuss that. Also, transparency, as we work with these innovators. They're looking at these new delivery systems. Also, I know you're working on RAC reforms, and we'll want to discuss that, the RAC audit process and look at whether or not a shot clock would be helpful in that. And I appreciate your being here to give us insight into what the trends are with your budget and what your expectations are for reducing the size of that budget with your outlays.

And so, thank you for being here, and I yield back.

PITTS:

The chair thanks the gentlelady.

And I recognize the ranking member of the full committee, Mr. Pallone, five minutes for an opening statement.

PALLONE:

Thank you, Mr. Chairman. And thank you, Secretary Burwell, for joining us this morning.

Today we're meeting to discuss the president's fiscal year 2017 Health and Human Services budget proposal. And as is often said, budgets are about priorities, and I'm pleased to see that the president's proposed budget aligns quite well with what should be the top priority of this committee, and that is ensuring access to high- quality affordable health care for all Americans.

First and foremost, the budget recognizes the simple truth. The Affordable Care Act is achieving its goals. As a result of the ACA, 18 million Americans have gained access to both high-quality health insurance and the peace of mind that comes with maintaining coverage. Of course, more could be done, which is why I'm pleased the president proposed additional incentives for the remaining states that have yet to expand Medicaid.

Medicaid expansion has been life-changing for the millions of Americans that have been able to access health coverage through Medicaid, many for the first time in their lives. In the 19 states that have yet to expand Medicaid, more than 4 million could gain coverage, states could realize major savings in other parts of their budgets, and over $4 billion in uncompensated care costs could be avoided. And Democrats have already introduced legislation to put the president's proposal into action, and Congress should act swiftly to enact that bill into law.

Beyond building upon known successes, the budget also directs funding into known areas of need. To put it simply, our nation's biomedical research budget is simply inadequate. As a committee, we've already recognized and acted upon this fact when we passed the bipartisan 21st Century Cures Act. In that same spirit, I applaud the proposed $755 million allocated for NIH and FDA through the vice president's national cancer moonshot initiative. Over 1.6 million Americans will be diagnosed with cancer this year, and it's our responsibility to ensure that all Americans have the best shot at a cure.

And finally, the president's budget recognizes the devastating effects of the heroin and opioid abuse crisis. Sadly, my home state of New Jersey is not immune from this epidemic. In fact, if every one of our New Jersey residents addicted to heroin or prescription opioids lived in the same city, it would hold a population larger than that of New Jersey's largest city. And that's why I've introduced a comprehensive bill, H.R. 4396, the Heroin and Prescription Drug Abuse Prevention and Reduction Act, to address heroin and prescription drug abuse. I'd like to thank you for your strong leadership on this issue, Madam Secretary, and I urge the committee to act quickly to put a halt to this public health emergency.

Finally, just as a side note, Secretary Burwell, I know I will not have enough time to discuss this issue today, but I would like to have a follow-up conversation with you about the Indian Health Service. Specifically, I would like to address concerns that have been raised about the quality of

care provided by hospitals in the Great Plains area, as well as to get an update on the continued implementation of the Indian Health Care Improvement Act, which, of course, was included in the ACA.

But I had two minutes left. And I'd like to split that because Representative Matsui and Representative DeGette and yield one minute now to Representative Matsui.

MATSUI:

Thank you so much. Secretary Burwell, welcome.

This budget definitely is something that makes critical investments in the long-term health and well-being of America's families. From supporting expansion of Medicaid for millions of low-income Americans, investing in medical research to bolstering the behavioral health workforce so that patients with mental illnesses have some place to turn, I'm especially pleased with the incentives you put in for community behavior health centers.

The Affordable Care Act has improved millions of Americans' lives. Thanks to the ACA, nearly 18 million previously uninsured Americans no longer have to worry that they have -- they're one illness away from financial ruin.

I'm very pleased that this HHS budget makes the critical investments in order to ensure the continual success of the Affordable Care Act. And this budget makes clear also affordable care is intertwined in the fabric of our health care system. It is time that we move forward with implementing all aspects of it. And thank you very much.

And I yield to my colleague.

PALLONE:

Ms. DeGette?

DEGETTE:

Thank you very much for yielding, Mr. Pallone.

I just want to underscore something that both Chairman Upton and you talked about, and that's the importance of the 21st Century Cures Act, which passed this committee unanimously. To make the investments that we talk about in that bill effective, we need to provide leaders at the NIH the ability to make decisions with some kind of freedom from the back-and-forth budgeting and appropriations process. After all, it's that process that couple with damaging cuts from the sequestration set our medical efforts back a long way.

And that's why mandatory funding created in the 21st Century Cures Act innovation fund is so important. For too long, budgetary pressures have kept promising research projects from being carried out. And with the stability of the innovation fund, researchers could submit proposals that

would not otherwise be guaranteed the funding needed to complete the science. That was the approach that the House overwhelmingly supported, and that's the approach that we're trying to work on in the other body.

So as much as you can do, Madam Secretary, that really helps us out in our efforts. Thank you very much. And I thank you, Mr. Chairman, for the comity in allowing me to sit in on this subcommittee.

PITTS:

The chair thanks the gentlelady. That concludes the opening statements. As usual, all members' written statements will be made a part of the record.

We'll now go to our panel. And I'm happy to welcome the Honorable Sylvia Mathews Burwell, secretary of the Department of Health and Human Services, as our witness today. Thank you for coming.

We have your testimony, the written testimony, made part of the record. But you will be given five minutes to summarize. So at this point, the chair recognizes Secretary Burwell five minutes for her summary.

BURWELL:

Thank you. Chairman Pitts, Chairman Upton, Ranking Member Pallone, and Representative Castor, members of the committee, I want to thank you all for the opportunity to come and discuss the president's budget here today. As many of you all know...

(UNKNOWN)

Can you pull your mike closer, please?

PITTS:

Just pull it a little closer, yeah.

BURWELL:

As many of you all know -- better? As many of you all know, I believe that all of us actually share common interests and that we can find common ground. And the last legislative session, as was mentioned, this committee embraced that spirit of bipartisan leadership when it took the historic steps to pass the Medicare Access and CHIP Reauthorization Act of 2015.

And thank you very much for this leadership on this issue. The budget before you today is my final budget and the final budget of this administration. It makes critical investments to protect the health and well-being of the American people. It helps ensure that we can do our job to keep people safe

and healthy, accelerate our progress in scientific research and medical innovation, and expands and strengthens our health care system.

And it helps us continue to be responsible stewards of the taxpayers' dollars. For HHS, the budget proposed $82.8 billion in discretionary budget authority, and our request recognizes the constraints in our budget environment and includes targeted reforms to Medicare, Medicaid and other programs. Over the next 10 years, these reforms to Medicare would result in net savings of $419 billion in Medicare.

This budget invests in the safety and health of all Americans. And let me start with an issue we've been working on here at home and abroad. As we work to stop the spread of Zika, the administration is requesting $1.9 billion in emergency funding, including $1.5 billion for HHS to enhance our ongoing efforts both domestically and internationally. We appreciate the Congress's consideration of this important request as we implement the essential strategies to prevent, detect and respond to this virus.

I know the rise in opioid misuse and abuse and overdose has affected many of those in your districts. Every day in America, 78 people die of opioid-related deaths, and that's why this budget proposes significant funding, over $1 billion to combat the opioid epidemic. Today, too many of our nation's children and adults with diagnosable mental health disorders don't receive the treatment that they need, so this budget proposes $780 million in new mandatory and discretionary resources over the next two years.

This request will ensure that the behavioral health care system works for everyone. It will help expand behavioral services and workforce capacity so that more people can have access to care. And it will help individuals with serious mental illness get engaged and get the care that they need.

While we invest in the safety and health of Americans today, we must also relentlessly push forward the frontiers of science and medicine, and I know this committee is deeply involved and engaged in that issue. This budget invests in the vice president's cancer initiative. It's a vital investment for our future. Each 1 percent drop in cancer death rates saves our economy approximately $500 billion. Not to mention the comfort and security it can bring to so many families.

Today, we're entering a new era of medical science, with the proposed increases of $107 million in the precision medicine initiative and the $45 million additional for the administration's brain initiative. But for Americans to benefit from these breakthroughs in medical science, we need to ensure that Americans have access to affordable, quality care. The Affordable Care Act has helped us make historic progress, and today more than 90 percent of Americans have health coverage, the first time in our nation's history. This budget seeks to build on that progress by improving the quality of care that patients receive, spending our dollars more wisely, and putting an engaged and empowered consumer at the center of care.

By advancing and improving the way we pay doctors, coordinate care, and use health data and information, we're building a better, smarter and healthier health care system.

Finally, I just want to thank the employees of HHS. In the past year, they helped us with the Ebola outbreak in West Africa. They've advanced the frontiers of medical science. They've helped millions of Americans enroll in health coverage. And they've done the quiet day- to-day work that makes our country stronger.

I'm honored to be a part of the team. And as members of this committee I hope know, I'm personally committed to working closely with you and your staff to find common ground so we can deliver for the American people. And with that, I look forward to your questions. Thank you.

PITTS:

Thank you, Madam Secretary. I will begin the questioning, and recognize myself five minutes for that purpose.

Secretary Burwell, on February 12th, the administration announced that they would be using billions of taxpayer dollars to make payments to insurance companies under the Obamacare reinsurance program. There's a quote on the screen there from the ACA. It says notwithstanding the preceding sentence, $2 billion for 2014, $2 billion for 2015, $1 billion for 2016 shall be deposited into the general fund of the Treasury of the United States and may not be used for the reinsurance program.

So the announcement that the announcement make represents an illegal wealth transfer from hard-working taxpayers to insurance. And this law is very clear, $5 billion of reinsurance fees must be returned to the taxpayers. And as you can see, Section 1341 of the ACA states that this $5 billion, quote, "shall be deposited," end quote, into the Treasury, and if that wasn't clear enough, the law further states on down that these billions of taxpayer dollars, quote, "may not be used" for the reinsurance program. Seems clear.

Yet CMS to date has diverted $3.5 billion from the Treasury to health insurance companies, effectively bailing out insurance companies with taxpayer dollars. So my question to you, Madam Secretary, is this. Has any HHS official or any other administration official looked at the legality of these payments? Is there any legal memorandum or other analysis regarding the legality of these payments to insurers? And will you produce any such memorandum for the committee, if so?

BURWELL:

So the reinsurance program is part of three different programs that are about making sure that we have downward pressure on costs for individuals in the health insurance system. That's downward pressure on premiums. This particular program is a limited program for three years, and that's all. Of the three programs, one extends, which is the risk adjustment program. This one, the reinsurance program, does not.

The reinsurance program, as I said, was put in place so that two things would happen for people entering the new market. In a new marketplace where they didn't know, you didn't want people not coming in and offering competition for downward price pressure because they feared that they would get people who are expensive. And then in addition to that, it puts downward pressure so

that when you do get people that are expensive, you know in these first years as you're understanding your book of business and doing your analysis to be able to price correctly that you have that opportunity.

So in making any decisions about these issues, we believe we do have the statutory authority with regard to this issue. And in making the decisions -- and this gets to a point that I think Ms. Blackburn was -- who raised in her opening comments -- the issues of making sure we're clear about lessons learned. And one of the most important lessons, customer at the center.

And the consumer or the citizen is what we've tried to put at the center, and whether that's in the decisions of how we've done the technology or how we make decisions about ensuring that those dollars actually went to the place where they would most help the consumer with regard to downward price pressure. And it is our belief we have that authority, and if it would be helpful, we can have staff come and brief in terms of why we believe we have those authorities.

PITTS:

And do you have a legal memorandum to that effect?

BURWELL:

With regard to the question of a legal memorandum, this is an issue actually we put out our guidance for public comment. We put out the guidance that articulated that we would do this, and when we put out that guidance, we actually opened up for public comment specifically, and we can go through what public comments that we received with regard to that.

PITTS:

We have a legal memorandum. And I'll ask staff to deliver maybe you have it before you -- should be a memo from the Congressional Research Service (inaudible) and on page eight, highlighted before you, the memo states that your action to divert funds from the Treasury, quote, "in conclusion would appear to conflict with the plain reading of the law."

So my question is, CRS has concluded that your action to divert billions to insurance companies appears to be unlawful. Did your department receive any pressure from insurance companies to divert billions from taxpayers to pay off insurers? Did former CMS Administrator Marilyn Tavenner, now representing the insurance industry at AHIP, or other insurance company executives or officials ever pressure you or other department officials on the reinsurance issue?

BURWELL:

Mr. Pitts, I'd be happy to take a look. I have not seen this document that was just handed to me. We'll be happy to take a look at that document and get back. We do believe we have the authorities. As I said, I think I've given you the context, the approach we take to making these decisions. And since I have come to HHS, it is one of the key things, one of the key things that I started out with, with the whole team is, consumer at the center.

And as we make decisions, what we try and do is make those decisions by putting that customer and their needs, whether that's as I said in website decisions and trying to make it easier to use or with regard to matters like this, in terms of where those funds go, so that we create that downward pressure as much as possible within statute to put downward pressure on premiums instead of upward pressure on premiums.

PITTS:

The chair thanks the gentlelady.

CASTOR:

Mr. Chairman, before you finish, can you identify the source of that slide? Because as we know, in other congressional hearings over the past few, there's been a little funny business on where those slides come from.

PITTS:

That is a direct quote from the Affordable Care Act from the statute. That's from the statute. My time is expired. The chair now recognizes the gentlelady, Ms. Castor...

CASTOR:

Did you have a statutory cite on that? Because it didn't appear to be a statutory...

PITTS:

Yes, I cited it, Section 1341. The chair now recognizes the lady from Florida for five minutes for her requests.

CASTOR:

Great, thank you very much.

Madam Secretary, I'd like to ask you to give us an update on Medicaid expansion across the country, but before you do that, I want everyone to be aware that a new bill was just dropped last night by Mr. Green. The Incentivizing Medicare Expansion Act. It already has 15 co-sponsors, including myself, Mr. Tonko, Mr. Butterfield, Ms. DeGette, Ms. Matsui, Mr. Pallone, Mr. Kennedy, Mr. Lujan, and others, and it mirrors the very smart provision in the budget that provides a new incentive to the states that have not expanded Medicaid.

Because as I said in my opening, it simply is completely unfair that some citizens have the ability to seek medical care under the Medicaid expansion in some states, and because of politics in others, they don't. So we know what the Supreme Court said. It's not mandatory, but it is very important that we continue the incentive, because it's smart, fiscal policy.

I know in my state we would save a lot of money, we would create jobs, and we would take care of our neighbors if the cadre that's in control of the state government right now would listen to the people and expand Medicaid. But tell us -- give us an update on how it's going and what the source of your incentive under the budget was for those states.

BURWELL:

So we know right now, 30 states plus the District of Columbia have done the expansion. The information that we are now receiving in terms of those expansion states, whether that's the benefit to individuals, which we are seeing many more people having -- doing adherence in terms of those who have medical conditions going, taking their medication and those sorts of things because of the expansion, so the benefit to the individual is both a health benefit, as well as a financial benefit.

But we also know that the benefit to states is something that we're seeing. And that conversation is going on all over the country. And whether that's in Kansas or the legislature in Maine, in terms of proposals to go forward to try and have Medicaid expansion, and a big part of it is the benefit. And we know that in the state of Kentucky, the estimates are that there will be 40,000 more jobs by 2021 and $30 billion to the state in terms of money that will flow into the state.

And I think those benefits are already starting to be seen in states where what we're seeing in terms of rural hospital closures, an issue that I think many of us are concerned about, is that more of those closures are occurring in non-expansion states. And that other part of this I think is the issue of the uncompensated care. And the estimates are since the beginning of the Medicaid expansion and the coverage expansion that's resulted in the 90 percent coverage that we estimate that there have been about $7.8 billion in a reduction in uncompensated care.

And those reductions are not spread evenly: 68 percent of that is in states that have expanded. So both about the individual in terms of their financial and health well-being, but also in terms of the economics both of the state and the community, we believe this proposal is a proposal that supports governors' desires.

I spend a lot of time -- just last weekend, spent time all weekend, Friday, Saturday and Sunday and Monday, with the governors that were here from the National Governors Association, and these are important conversations that we're having with them, about the economic needs in their state.

CASTOR:

Well, you know, over 50 years ago, when the Congress first adopted Medicaid to provide that lifeline for children and their older neighbors, all states didn't jump in right at first, but eventually over time didn't they all join the Medicaid world?

BURWELL:

They do. And I think because of the benefits this will provide -- and a number of issues we'll talk about -- behavioral health is one I'm sure we'll spend time on in this committee, and we know that that Medicaid expansion will make a difference in terms of these behavioral health issues, as well.

CASTOR:

Thanks. And one other issue. There is a lot of bipartisan interest in Congress to address graduate medical education, and if we can fix the doc fix, I know we can make progress on graduate medical education. We know we have a looming doctor shortage. We know that since 1997 there's been a cap and it's been static where residency slots exist across the country. But I think there is this newfound momentum, bipartisan, in the Congress to do some creative things, but we will need your help.

Most folks don't know that residency positions are paid for by Medicare. I think we can stretch the Medicare dollar by creating innovative partnerships with health providers and hospitals across the country. There is legislation to do so. Sean Cavanaugh came over and talked about it. He said this could be an area to take that Medicare dollar, expand it, and provide the doctors we need in the areas we need in the future.

So can you commit to doing that over the next -- during your remaining time?

BURWELL:

I look forward to work -- I hope you see our GME policy for children's GME, responds to many of the concerns that were expressed to us last year, in terms of the proposal we have now. So I look forward to working on these issues.

PITTS:

The gentlelady's time expired. And the chair now recognizes the chairman of the full committee, Mr. Upton, five minutes for questions.

UPTON:

Again, thank you for being with us this morning. I really want to focus on two things -- cures and Flint. And let me ask you first about cures, and when we get about halfway the time, I'll try to -- I hope not to be rude, but I want to make sure that we cover both.

We've worked so closely on this. And again, I thank your staff for the technical assistance, particularly on precision medicine, which we included in the bill, which as Ms. DeGette said, passed the committee 51-0. I know that you are a part of the vice president's task force, so under the executive order for the national cancer moonshot. You've had at least one meeting, maybe a couple. We have been -- Mr. Pallone and myself and DeGette, as well as senators, have been working with the vice president's office. We're hoping to sit down next week formally to see exactly where we are.

But what are some of the ideas in addition to what we have in the cures that you think that we might be able to incorporate? Our idea, of course, is to take the House-passed bill already. Senate has begun the markup stage in the last two weeks, and they're looking at doing a series of bills, which are all bipartisan at this point, intend to be so, Mr. Alexander and Ms. Murray, and then to look at injecting the cancer initiative as part of that process, go to conference and accept all the good parts, which is in essence the whole thing.

But what additional ideas are you all thinking about as part of that initiative as we begin to move forward?

BURWELL:

So, first, thank you for your leadership and the leadership of other members of this committee. In the 21st Century Cures space, the PMI space, and now this space, as well, we're excited about working in that space. A couple of the things that I would be specific about in terms of places where I think we can build on the work that you all were already doing in your bill are some of the key areas what we want to do investments in. Some of those have to do with immunology, in terms of advancing that science, where we know that people's own immune systems are some of the best ways that we can advance the ability to treat cancer, as well as it's good overlap with some of the proposals that we're thinking about in the cancer space are related to genetics, and that overlaps very directly with your PMI work.

I would also mention -- and I'm sure you'll have the conversation with the vice president and I always welcome it, too -- is as we think about making sure that FDA -- I think you know -- we have suggested that FDA actually have a particular expertise and develop a part of FDA that is cancer and oncology focused. I think we think that's an important addition to our work. And so those are some of the specifics of what we do.

We also look forward to your all's ideas about how we can expand access to trials. And that's something I think we want to have those conversations with you about and as you reflected before we get to the end of the process have those conversations earlier.

UPTON:

Well, that's great. And we look forward to meeting with the new FDA director. I don't know if he was formally confirmed yesterday. I know that I think the vote's out of -- I think he's been confirmed, but he's not been sworn in yet, so...

BURWELL:

Votes will hopefully be today at noon or 1:00.

UPTON:

We look forward to that. Let me just switch now to Flint. And, again, your office has been most helpful. Dr. Lurie has had very good reviews we've dispatched to Michigan over the last number

of weeks. Our Michigan delegation on a bipartisan basis is meeting with her today. I know that you were there last week.

I talked to our governor earlier this week specifically about this, and I know that he's got a number of waiver requests that are in. CHIP expansion for pregnant women and children up to the age of 21, increased Medicaid eligibility for lead abatement activities, a number of things. Just can you tell me where we think -- where you all think you are in terms of the requests that Michigan has put forward?

BURWELL:

As I articulated with the governor and when I was in Flint, I think we will be able to approve an expansion of Medicaid that will be for pregnant women and children. That will be a major expansion. It will also include something that's pretty important which is comprehensive targeted approaches to individual management, so that when we understand that a child has had a certain level of exposure that we make sure that they receive the comprehensive services that they do. And that's another part of the waiver conversation.

So my expectation is that we will be able to do most of what is in that waiver and that we will get that done quickly.

UPTON:

And knowing that you were there last week, the water is still unsafe to drink. Is that correct?

BURWELL:

So with regard to water, at this point, people should either use the bottle or -- filters. But once you have a filter that is appropriately installed and you do the directions in terms of the changing and the cleaning of your filter that you need to do, that water should be safe. And if you want it tested, though, call 211. Anyone should just call 211 to make sure if that's what you want for comfort.

If you're a pregnant woman, or if you're a child under six, we recommend out of an abundance of caution use the bottles. But otherwise, filters applied -- and those filters are being tested, and EPA continues to test regularly.

UPTON:

Thank you. Yield back.

PITTS:

The chair thanks the gentleman. I recognize the ranking member of the full committee, Mr. Pallone, for five minutes of questions.

PALLONE:

Thank you, Mr. Chairman.

I wanted to ask Secretary Burwell, in your testimony, you noted that part of the goal of the budget is to build upon the successes of the Affordable Care Act, and the latest round of open enrollment just recently ended. Can you tell us more about how this open enrollment has gone, including how many people signed up for health insurance, how many were eligible for tax credits to make insurance more affordable?

BURWELL:

So with regard to this open enrollment, 12.7 million Americans enrolled in this open enrollment. There are some other things that I think are important about the open enrollment that get to some of the broader issues that I'm sure we're going to discuss.

We know that of those folks, there were 4 million new people that came in. Of the 4 million new, 60 percent of them signed up for coverage for January 1st. Why is that important? It says it's a product that they want and they want to start at the beginning of the year. It's also important because from an insurance company or an issuer's perspective, you want them in for the full year, in terms of downward pressure, again, on price.

The other thing that happened in this open enrollment in addition to that 12.7 million is when you look at the people that were in before -- so I talked about the new, but the other folks, 70 percent of the folks who had been enrolled last year and came back and are reenrolled America took some action. They came in, updated their information, or they shopped. This an engaged, empowered, educated consumer making choices.

If I asked in a setting where there's employer-based coverage, those numbers generally don't even ever get above 10 percent in terms of the number of people who engage in a reenrollment process. So it's an engaged consumer. It's a consumer that's seeking that product. And so those are some of the highlights of what we've seen in this year's open enrollment.

PALLONE:

OK, thanks. I know that the gentlelady from Florida mentioned Medicaid expansion. And the president has proposed these additional incentives for states to expand Medicaid. Could you describe the benefits that Medicaid expansion -- that the states are experiencing and why it's so important that the remaining 19 states join them in moving forward?

BURWELL:

So as I mentioned, it's the advantage in the benefit to the individual. And I'm sure you all meet folks every day who it makes a difference in terms of their ability to get the health coverage they need, and whether that's the preventative services they need to prevent other things or when they have something going wrong, their ability to treat those. And so that's the individual.

But the economics benefits of this and the other benefits we've seen, that the number of people in the country now who are struggling with making their health care payments has gone down as a nation. We have seen the New England Journal of Medicine most recently put out a study saying that the changes through Medicaid expansion are affecting payer mix for hospitals and making a difference to them on the ground.

And so it's both about the individual, the communities, and the states, as we think about those benefits.

PALLONE:

And then lastly, I wanted to ask about the proposals in the president's budget to address the opioid abuse and overdose crisis. The president's 2017 budget requests $1 billion in new mandatory funding over 2 years to expand access to treatment for prescription drugs and heroin use. Can you just walk us through this funding request? Why is this investment necessary? Why is our current treatment capacity insufficient? Why is it important that the $1 billion be provided in the form of mandatory funding over the 2 years? And how is this going to be allocated?

BURWELL:

With regard to the money that we have asked for, it is most to support an evidence-based strategy that we have talked about. And let me just hit those points, because that is where the money will go. The first area is in the area of prescribing, and we know that part of what is contributed to the issue of the opioid epidemic is overprescribing.

And so it is money to support the efforts of new guidelines that will come out from CDC and making sure that those guidelines are actually used, learned, and applied. The second areas is in the area of medication assisted treatment. And this is the space where the vast majority of this money goes. And it goes to that, and it will go through -- it will go to communities and states. This is money that will not be, you know, used at HHS, but will go to communities and states, and this is part of what we know. Behavioral health is something that has been a local issue for so many years. It's paid for mainly at the state and local level.

And so making sure that the communities can have the access -- right now, I was told 2 weeks ago that in 85 percent of the counties, rural counties in this country, that their ability to have behavioral health providers and access is quite limited. And so that money -- and that's the vast majority of the money in the budget.

The last area is in the area of naloxone or Narcan. And that is sadly -- we know that in our communities people are overdosing. And so to prevent them from dying, you apply naloxone or Narcan. There will be money to go to the communities to get that access to that drug, so in the last case scenario where we have someone who's overdosed, we can at least have first responders and community members that can save lives.

PALLONE:

Thank you so much.

PITTS:

The chair thanks the gentleman. I now recognize the chair emeritus, Mr. Barton, five minutes for questions.

BARTON:

Thank you, Mr. Chairman. Before I ask my questions, I want to file a mild complaint. The secretary called me on my cellphone the other day and was very charming and disarming. It makes it very difficult to ask her tough questions when she's so polite and receptive to my input. So we may want to consider adopting a rule that cabinet secretaries at least of the opposition party of the majority cannot do that.

(LAUGHTER)

So just want to put that on the record.

PITTS:

We'll take it under advisement.

BARTON:

Madam Secretary, it's always a delight to have you come before the committee and answer questions that are usually not at all related to the budget, which you're supposed to be prepared to answer.

I've got a difficult question and an easy question. Which do you want first?

BURWELL:

Difficult.

BARTON:

The difficult question. I'm surprised at that.

BURWELL:

I think you know me.

BARTON:

There are many of us that are very concerned about the issue of harvesting and selling what you could either call baby parts or you can call it fetal issues, whichever term you choose to use. I'm very concerned about that, not opposed to family planning, not opposed to funding women's health issues at all.

My staff has done some research and found out that the last time the issue of fetal tissue research was studied was during the Reagan administration. There was a special commission appointed by the president that did a study. That's over 30 years ago. There have been tremendous changes in medical practice and medical research since that time.

The NIH is not currently funding such research internally, but externally, they have supported about $76 million in such areas of research outside the NIH. Would you support a new commission to take a look at this issue so that regardless of which side you're on of the politics, we could at least know what the facts are?

BURWELL:

With regard to the issue, I agree with you that this is an issue of great emotion and focus on different sides of the issue, and I respect that there are differing opinions on the issue. With regard to the question of the use of this tissue as part of our research that we do, I think in terms of the basics of the question of the value of that research, we continue to see -- and whether it's the fact that the measles vaccine, the mumps vaccine, Hepatitis A, are all products that have derived and come out of this research, to the fact that some of this research has helped us move in a very -- in terms of the research that was done for the Ebola vaccine.

And so for us, the question of the research when done appropriately and in accordance with the laws and the statutes -- and, you know, no valuable consideration -- are things we take extremely seriously.

BARTON:

You support a new commission to review the issue?

BURWELL:

I would welcome the opportunity to have the conversation. I think the question is, is to understand which issue, because I think at its heart is the question of the value of this research. And the question of -- I think in terms of the guidelines that are put in, which are very strict, are there issues or problems with that? So I would welcome the opportunity to understand more fully what you think are the issues around this that we would...

BARTON:

Well, the gentlelady next to me on my right, Ms. Blackburn, is heading up a select committee that I believe is going to be looking into this. So...

BURWELL:

And I think we have responded, both the department and NIH as an operating division, to your question, Ms. Blackburn.

BARTON:

Well, here's my easier question. The majority of this committee has sponsored a piece of legislation that we call the ACE Kids Act. It would change federal policy to create a medical home for families that have special needs children. It would allow there to be an anchor hospital that would then create a network so that if you had a child who was a special needs disadvantaged child with multiple medical conditions, they could come into the network and there would be a single home.

We have a majority of the committee and we have almost a majority of the House of Representatives as co-sponsors. Has your office taken a look at that legislation? And if so, what's your position on it?

BURWELL:

We welcome the leadership that you and others have provided in this area of complex cases. We're continuing to work right now with our administrative authorities to work with states in order to get the kind of care and service that you're talking about for parents and their children. And so we want to continue to work on that. We have a proposal in our budget that extends that, because one of the things is, when some of the states do this, it carries over not for just children, but for larger populations, and sometimes that's why states are hesitating.

So we look forward to working in terms of, as I said -- we have a proposal in our budget, would like to have the conversation about -- I'm not sure if your legislation includes that part of it or not, but I think we're with you on the objective of helping families with this complex care.

BARTON:

Thank you. Thank you. And thank the chairman for his discretion.

PITTS:

The chair thanks the gentleman and now recognize the gentlelady from California, Ms. Capps, for five minutes for questions.

CAPPS:

Thank you, Mr. Chairman, and thank you, Secretary Burwell, for your testimony today.

The president's budget proposal this year includes many important investments in our nation's health care delivery system, workforce, and prevention programs. HHS programs touched each

one of us in some way, whether it's a Medicare beneficiary, someone needs a tobacco cessation program, or perhaps being cared for by a health care provider trained with federal funding.

I recognize that balancing the many competing priorities in this space is a challenge, and appreciate your efforts on this. Today I'd like to highlight two different programs that very much deserve your strong support and ask a question about each of them. Specifically, I'd like to highlight the importance of the federal investment in the training and retention of the nursing workforce.

Title 8 provides critical federal grants for nursing schools and organizations to advance their educational programs to promote diversity in the field, repay loans for nursing students who work in facilities with critical shortages, and train geriatric nurses. Our nation faces a significant challenge of caring for our growing patient population with limited resources. Title 8 nursing workforce programs, progress that have been around since 1964, are a key component to this effort because they train highly skilled health care workers can serve in hospitals, research labs, and communities.

Will you discuss briefly what this budget request does to support the development of highly qualified health care workforce important today and known as the Title 8 programs in ways that it can be continued?

BURWELL:

So over $200 million in investment, and those are split basically in two different pieces. The first is actually education, as you mentioned, in terms of educating and training, in terms of that supporting the provider community. The second part is actually with loan forgiveness programs that help us have those trained professionals go to the places where we have shortages and needs. And those are the two main ways.

But throughout the budget and throughout the proposals that are before you now, there are a number of things that I think are supportive of the nursing community, because we believe they are part of getting us to a system where we have better quality care and a more affordable way. And so having nurses and other health practitioners operate at the top of their license and steps that we're taking -- for instance, in our budget, we actually propose with regard to buprenorphine, which is an important medication assisted treatment for opioids, we are proposing that it is considered by the Congress to expand those that can prescribe if they meet certain conditions.

So we're supporting it in terms of our funding, but also in terms of how we think about the role of the nurse in a system that can improve quality and reduce cost.

CAPPS:

Thank you, Madam Secretary. And this is why I joined with my House Nursing Caucus co-chair to author bipartisan legislation to reauthorize Title 8, the nursing workforce development programs, with my colleague, Mr. Joyce from Ohio.

Another key priority for the administration and for many of us personally is making an impact on cancer treatment care and prevention. As you know, cancer continues to be one of the leading causes of death globally, with the number of new cancer cases expected to rise to 22 million within the next two decades. It's a huge number.

As one of the co-chairs of the Cancer Caucus, I commend the administration for launching the national cancer moonshot initiative. If we're going to win the war on cancer, we must take a comprehensive approach to this fight, as this initiative proposes to do.

Only 5 percent of cancer patients in the United States participate in the clinical trial. And most do not have access to their own data. I believe participation in clinical trials is so essential to finding new treatments and ultimately a cure for cancer, increase -- or cures for cancer.

Increasing data-sharing is also critical, as it can help to advance a better understanding of the disease and how best to treat it. Increasing participation in clinical trials, ensuring these trials include a diverse range of participants, including women of all backgrounds, ages and risk levels, is something I've long advocated for.

Madam Secretary, how will you, through the national cancer moonshot initiative, help to increase access to clinical trials in the area of cancer?

BURWELL:

So with regard to the issue of trials, as I mentioned in responding to Mr. Upton, about -- that is one of the issues that is a priority. In terms of things that we can do right now and should do right now and are doing right now, is this ties into the issues around electronic health records and precision medicine. And those are separate, but related issues, as is the cancer part of this, which is making sure that patients and consumers can get access to their data.

And this I think actually also relates to the issue that we were talking about with regard to 21st Century Cures on this side, but on the Senate side, I think Mr. Alexander and Ms. Murray are thinking of including things that would prevent data blocking. And data blocking is when the providers of software to electronic health records -- so a provider of software to a hospital -- does things, and sometimes they might be about cost, but sometimes they may be about making things really hard for the consumer to get that data information.

And so these are steps that I think we can take right now and are working on, and I will actually be speaking to at a conference of all the technology people as soon as this Monday. With regard to getting commitments from the private sector to work against this data blocking, and hopefully we can get there, but I think it's important that certainly your colleagues on the other side are considering legislation which we're in conversations with them about. And this would come together in the 21st Century Cures version, the House and the Senate coming together, when you all come together in a conference.

CAPPS:

Thank you very much. I yield back.

PITTS:

The chair thanks the gentlelady. Now recognize the vice chair of the subcommittee, gentleman from Kentucky, Mr. Guthrie, five minutes for questions.

GUTHRIE:

Thank you, Madam Secretary, for being her today. I really appreciate it. And as echo what my colleague said, working -- willingness to work together.

One of the big concerns I've had -- I was in state government before in Kentucky -- and since I've been here, it's the growth of Medicaid. And we're looking at how we deal with the growth of Medicaid, how we cover the vulnerable, but we have to do it in a way that's sustainable and for our budgets.

And I have -- I know you worked in the Clinton administration -- and I have a congressional record, a letter, and so I can show the documentation, but it was Senator Murray, and it was a letter that she sent to President Clinton -- or signed -- and I'll quote what she said on the floor of the Senate. Said, this letter is partisan, in that it is signed by all Democrats, which would include the vice president at the time he was in the Senate. But it is my feeling that as Americans, every member of the Senate should have an opportunity to endorse the position described in the document.

And I'll just read the opening of the letter. It says, we're writing to address our strong support for the Medicaid per capita cap structure in your seven budget. So as we're looking at all options and dealing with the Medicaid, Medicaid is now about three times what it was in 1995, three times the size. Would you support a per capita cap structure or Congress adopting that structure?

BURWELL:

So as we think about the issue of health care costs, which I think everyone agrees are what are driving our deficit over the long term, I think one of the things is separating out two issues. One is per capita costs, which is related to the issue you're talking about, and also the overarching cost. And as we as a nation move to have more people covered and we have a baby boom through Medicare, we're going to have to focus on those issues, as we think about it.

With regard to the questions of caps and how that works, I think the question -- and we're also seeing this right now in press release with Zika, which basically has a blocked approach to Medicaid, a block granted approach...

GUTHRIE:

Yes, right, yes.

BURWELL:

... that right now we're having a very difficult time. That is part of what we will need the supplemental money. That is part of why we have a proposal in our budget on Puerto Rico. And so the concerns that we have around those issues are, one, that what happens is, pressure gets put on the state or the beneficiary in ways that you end up with reductions in quality of care. And so those are suggestions and ideas -- I'm sorry I'm not familiar with the letter that you're...

GUTHRIE:

But it was just -- I think that was in President Clinton's budget proposals twice I think in the 1990s and just seeing -- and so I was just showing that they had -- it had bipartisan support, but even the vice president signed onto it in the Senate at the time. I was wondering if that's a direction that we need to go for that. Is that something you would support? But I do want to get to Kentucky, so I don't want to be rude, though. I actually don't want to be rude.

BURWELL:

Go ahead. Go ahead. We'll come back if we have time.

GUTHRIE:

But you did meet with our governor. As you said, you met with governors last week, and I understand from people that I've talked to and him -- I haven't talked to him. But people within the -- it was very productive and they really appreciated the time. One of the concerns, though, as we move forward, because the -- I know you quoted that a lot of money is going to flow to Kentucky through their Medicaid expansion, but also a proposal right now, it was like 9 percent cut in universities, for two years -- it was 18 percent over two years -- the universities and other levels of government, just because it's not just Medicaid, but Medicaid is a part of what -- part of it is public pensions, but Medicaid.

And so they're looking at ways to innovate, as you know, because you met with them. And like I said, I appreciate that. But there was a Vicki Wachino (ph) writing -- responding to some questions from the committee Medicaid -- the head of Medicaid at CMS, and she wrote, and I quote, in some cases where new approaches are being tested, such as Indiana healthy improvement plan -- healthy Indiana plan 2.0, approved earlier in 2015, it is also important to evaluate the impact of new approaches being tested in 1115 demonstrations before proving similar policies.

And I don't know if there's -- can you give examples where you had to have evaluations before you could move forward on others? Because I know -- I don't think CMS does it for stuff like delivery system reform programs, premium assistance, managed long-term care services and support services and managed care? So is there a criteria by saying you can't move forward on a similar plan until we evaluate that?

BURWELL:

So with regard to CMMI, the Centers for Medicaid and Medicare Innovation, you all actually gave us pretty high standards with regard to evaluation. And standards that are actually -- I think it's good, because I think we should meet high standards before we take a demonstration and expand it. So in that part of the work that we do, yes, we've seen that, similarly in the Medicare work in the delivery system reform work.

I think what we want to do is make sure when there are things that are new and untested that before we expand to other states that we know and understand -- I think it's important to reflect that...

GUTHRIE:

But this is CMS, not CMI, but it's CMS. But...

BURWELL:

CMMI is part -- is the Center for Medicare and Medicaid Innovation is what was created and is part of CMS in terms of how we're doing that. And so there's that center. There's the Medicaid center. And we work to align as much as possible.

But I think to get to the core of the issue that I think you're raising, every state comes in with a different history and a different desire, and those are conversations that I think most governors will tell you on both sides that I welcome to have the conversation. And that is what we will do.

GUTHRIE:

You understand that also in that quote was that innovations that work in some states may not work in other states. That's some of the questions. So if something doesn't work in one state, it still could in another state. So we appreciate your openness. And I know I'm out of time. But -- and we really need to make it work, and we need to be innovative to make our Medicaid system work, so I appreciate the opportunity.

BURWELL:

I think we want to make sure those folks stay covered and it's done in ways that improve quality and do downward pressure on cost as much as possible. So we agree...

(CROSSTALK)

PITTS:

The chair thanks the gentleman. Did you want to submit your letter for the record? Did you want to submit the letter for the record?

GUTHRIE:

Well, it's in the congressional record for the 1995 Senate, but I submit that for the record.

PITTS:

All right. Without objection, so ordered.

The chair now recognizes the gentleman from Oregon, Dr. Schrader, five minutes for questions.

SCHRADER:

Thank you. Thanks for being here, Madam Secretary.

BURWELL:

Thank you.

SCHRADER:

Always enjoy it. Is it accurate to say that the total discretionary budget authority for your department, HHS, is actually $658 million less than it was in 2016 for 2017? And even with accounting for rescissions, it's $441 million less than in 2016?

BURWELL:

That is correct. Our discretionary...

(CROSSTALK)

SCHRADER:

I appreciate it. There are very few agencies that come in, realizing we're in tough economic times, that willing to take a little hit in the budget arena and make sure things balance. And it's not at the risk of patience, which I also appreciate. We're getting better health care out there, as you've testified.

And I also want to appreciate the fact that the administration is committing to 85 percent of Medicare payments being tied, frankly, to positive health outcomes by the end of 2016. I think that is the future. We're having great success on the CCO level in Oregon in our Medicaid expansion project, are actually getting more for less. The patients love it. The health care providers are very excited. We're getting great outcomes in terms of reduced hospital stays, less ER visits, more primary care attention.

I had the mental health care providers in the other day, also part of the CCO expansion, so it's not just your physical health. They're starting to get at the stuff that Congressman Murphy and many of us are trying to get at to incorporate mental health in the holistic approach to folks. I think it's very, very, very exciting.

I guess I'd be interested in your update on the next-generation of ACOs, you know, in the Medicare area, where we're going, and with the outcome-based care that we're talking about.

BURWELL:

So in terms of this idea of getting an educated, empowered, and engaged consumer at the center of care, and we often call that delivery system reform, there are three basic tools that we are working against. One in payment reform, so that we're paying for that value versus volume. And you talked about that in terms of the statistics. And this year, we hopefully will meet the goal we set out, that 30 percent of Medicare payments will be in value, not volume, by the end of 2016.

The second area of focus is changing the way we actually deliver care. And this gets to some of the innovation projects that we are working on and measuring. One of those, for example, in terms of where we are seeing real progress, not to the point where it meets the standard of evaluation yet that we would expand, but we are seeing that in terms of long-term care for people in the homes and making sure that we are doing certain types of care in the home, we see a reduction in hospital visits for those in the home and we see $3,000 per Medicare beneficiary savings.

Now, we need to make sure that that can hold, but that's some of the progress that we're seeing in that space, and changing the way delivery -- keep people in their homes, give them the education they need, give them the tools they need to get the care they need so they stay at home, not be in hospitals.

The third area is data and information. We've talked a little bit about that with Ms. Capps.

SCHRADER:

Right. Well, I appreciate all that. And I think the ACOs -- Medicare Advantage is another way to get value-based care to folks, and particularly in the home care settings. I worked with Mr. Lance and Ms. McMorris-Rodgers on several innovative programs, and I hope the administration will look favorably on in terms of improving that health care delivery, getting it to the consumer, nice bipartisan issue, regardless of your view of the ACA in particular.

And I'm hoping that HHS will continue to work with this committee and other members on improving the innovation opportunities through Medicare Advantage and wonder if there's other things you're doing to improve things for beneficiaries in the Medicare Advantage program. It's working really, really out west in Oregon.

BURWELL:

And with regard to the ACOs, that is a place where we have had measurable results. And what we have seen -- the measure had to be that you do not reduce quality, but you have savings. If you can increase quality, that's even better. And we have seen that and the savings $300 million, $400 million in terms of that, and now we have a new generation of ACOs, the accountable care organizations.

With regard to Medicare Advantage, the issue -- one of the things I would highlight that we are working on right now is one of the challenges in Medicare Advantage is the question of people with socioeconomic difficulties and the star ratings and how those ratings perhaps might disadvantage those who have a population who have a number of chronic conditions.

And so we have taken steps to wait and include things for that socioeconomic -- we're spending time to understand more fully. We want to make sure we analytically base, what are the differences and changes people should have in payment, if they are serving a more difficult population? But in the interim, as we're finding more solutions, those are changes we're making.

SCHRADER:

Very cool. Last comment I guess I'll make is I had insurance agents in my office just the other day working really hard to get people enrolled, and when they have their circumstance change, need a special enrollment opportunity, they're having a little trouble accessing the website compared to during the open enrollment periods. So if you could just reach out to them a little bit and work with them to help them help people make those changes so that we save money, people get the health care they need, and they're not subject to penalties later on. I'd appreciate that.

BURWELL:

Absolutely. We'd like to reach out and find out so we can reach out directly. We'll do that.

SCHRADER:

Thank you. I yield back, Mr. Chairman.

PITTS:

I thank the gentleman. I recognize the gentleman from Kentucky, Mr. Whitfield, five minutes for questions.

WHITFIELD:

Thank you, Mr. Chairman, and, Madam Secretary, thanks very much for being with us today. We all appreciate the phone call.

And there's three issues I want to talk about. First of all, alternative payment models for oncology. CMS has already developed a model, the oncology care model, under the Center for Medicare and Medicaid Innovation. And from conversations that I've had with oncologists and others, they find the signup process to be overly complicated. They say that they're being encouraged to sever relationships with certain hospitals and that many of them are not being informed on whether or not their application is being accepted.

Now, as you also know, Cathy McMorris-Rodgers and Steve Israel introduced a bill called the Cancer Care Payment Reform Act, which we had a legislative hearing on in September of last

year, and that is an alternative model that oncologists very much support. They're the ones providing this care.

And so the impression that we're getting is that you all are determined that you're going to move forward on your model, and I simply would ask, would you work with the providers to see about developing a model that's acceptable to everyone?

BURWELL:

Absolutely would like to and would like to follow-up with your staff directly in terms of talking to some of the providers that you've talked to so we can get their input directly.

WHITFIELD:

Well, we appreciate that. Thank you very much.

Now, on another matter, over a year ago, this committee and the Ways and Means Committee staff started working with HHS regarding a program at the Affordable Care Act that was authorized called the Basic Health Program. It was never funded. There was never an appropriation for that.

There was a permanent appropriation for an Affordable Care Act program called the Premium Tax Credit. And the administration has been taking money from that program -- last year, $1.3 billion -- to fund the Basic Health Program. And as I said, Ways and Means has been contacting you all on a regular basis about this. Energy and Commerce has been contacting you on a regular basis about this asking for documents about how this is being funded without a direct appropriation.

And after a year of asking for these documents, Ways and Means still has not received them, and the Energy and Commerce Committee has still not received them. Will you all work with us to provide this information that the staffs are asking for?

BURWELL:

I think we are and continue to work. We have both been responsive in terms of letters. We've been responsive actually in the Ways and Means side. A briefing was asked for. We provided an...

WHITFIELD:

Well, let me just say this. I mean, I appreciate that, but I don't -- I'm not there, I'm not negotiating, I'm not even discussing it. But the staffs on both Ways and Means and on our committee tell us that what has been provided is very meager, that it is not the documents that they're requesting.

BURWELL:

Well, I think we want to continue to work and we will. I think we're trying to work cooperatively with all of the issues of oversight which we think are important. In this particular case, in terms of

the authorities, we believe the authorities exist. The authorities are for the same amounts -- they're the same types of money...

WHITFIELD:

So you -- I mean, you all feel like you don't need a direct appropriation, that you have other authority to do it?

BURWELL:

We believe that the authority...

WHITFIELD:

And that's what we want. The document, I guess, that provides that authority, that -- at least your interpretation. But you've said that you'll continue to work with our committee on it. We'd appreciate that.

BURWELL:

We will.

WHITFIELD:

One other thing I just want to bring up briefly, because I was involved in it, is a sunscreen legislation. As you know, skin cancer is the most common form of cancer in the U.S. And skin cancer is more prevalent than breast cancer, prostate cancer, lung cancer, and colon cancer combined.

And so these ingredients that have been on file at the FDA for approval since 2002, over 14 years, and many of these ingredients are being used in Asia, Europe, around South America, around the world, and yet we passed a bill specifically to encourage a more -- process that's more applicable to this. And even since then, there's been no movement 14 months later.

And I know that Johnny Isakson, Senator Isakson asked about it. I'm asking about it. So I hope that you all will tell us that we need to do something. Is there anything that we can do to facilitate this?

BURWELL:

We'd like to follow up, because I think maybe you can help us. Our concern is it goes on -- the new products that are coming on -- first, you know, in Europe, it's a cosmetic. We actually believe because it's going on your children 24/7 that we need to make sure that what is going through, is it absorbable in the children's skin? It's up for everyone, but of course we're focused on children. And are those chemicals going to do something negative?

And so I think if we have a conversation, there may be a way that you can be helpful in helping us get the information we need.

WHITFIELD:

Now, we'd love to do that, because we definitely want to protect these children, but also you have something pending for 14 years or 15 years, I mean, people are beginning to wonder a little bit.

BURWELL:

We look forward to...

WHITFIELD:

Thank you very much. And I yield back the balance of my time.

PITTS:

Chair thanks the gentleman. Now recognize the gentleman from Massachusetts, Mr. Kennedy, five minutes for questions.

KENNEDY:

Thank you, Mr. Chairman.

Madam Secretary, thank you again for making an appearance today. I'd like to commend the president's budget for including critical forms to mental health and Medicaid, such as ending the 190-day lifetime limit on psychiatric inpatient care for Medicare beneficiaries, and for expanding the electronic health record incentive program for including behavioral health providers. It's a big step forward.

I also support the president's proposal to reinstate the primary care bump, which according to one study resulted in an increase of appointment availability by 7.7 percent. Do you think it's fair to say, Madam Secretary, that this proposal could also expand the program so that mental health and behavioral health providers in Medicaid could benefit from the bump, as well?

BURWELL:

Yes, I think we think that it's a continuum and there are a number of different proposals, as you articulated, that are focused on getting us to a different level with regard to access to behavioral health and integration as Mr. Schrader mentioned, in terms of integration of behavior health.

KENNEDY:

So do you agree that adequate reimbursement levels are a critical piece to expanding the workforce to ensure that Medicaid patients have access to timely care?

BURWELL:

So we do. I think you know our proposal on primary care that we have in our budget is about making sure that we do some of that. In addition, the proposal we have on behavioral health is actually focused specifically on some provider issues in terms of getting more providers so we have that access.

KENNEDY:

The president's budget, I believe, Madam Secretary, also proposes lifting the federal exclusion that currently prevents some children from getting Medicaid coverage of early and periodic screening diagnosis and treatment services. In layman's terms, that means kids on Medicaid can't get both mental health care and physical care while they're patients at certain facilities known as IMDs.

Madam Secretary, can you tell us a little bit more about the importance of ensuring that all children, regardless of the setting, have access to comprehensive health?

BURWELL:

We think it's important, which is why we have the proposal. I think it's an issue that I'm sure we may discuss also with Mr. Murphy, too, in terms of making sure that these kids have that access and have that access -- what happens -- and if you visit facilities, when you're a parent and you're told, oh, here's a prescription, you have to go at a different time and a different place or it won't be paid for in the same way, that's prohibitive in terms of having a child get the services that they need as they need them, a warm handoff.

So whether it's in the facility itself and the payment mechanisms really make a difference to how children are receiving this kind of care. Our proposal is aimed at trying to help that along.

KENNEDY:

Thank you. I want to touch base a little bit on I believe what Ms. Capps was getting at, as well, with regard to data. There's 14.1 million Americans in 31 states that have enrolled in Medicaid as a result of the Affordable Care Act and an additional 4 million could gain coverage if the remaining states expand their Medicaid programs. These numbers represent obviously far more than just facts and figures. They are about prenatal appointments, cancer screenings, and life saving preventive care.

Perhaps most noteworthy, Medicaid expansion means that millions of Americans now access mental and behavioral health care. Medicaid is the largest payer of mental health services in the United States and has the greatest potential to reform our broken system.

In order to make the necessary reforms and to bolster the program more effectively, we need to first know how CMS reimburses doctors and at what levels. However, when I talk to doctors and

patients, and I ask how much Medicare reimburses for their services, no one is able to point to exact figures, given the nature of those reimbursement mechanisms across states.

So, Madam Secretary, I would love your help in working with me on solutions to try to improve CMS's data collection for each state so that we can ensure that we know at least how the payments stack up against private insurance.

BURWELL:

I want to work on that issue. One of the things is, because Medicaid is a state-run program, you know, we are very dependent on the states in terms of their analytics, their data, and their systems. Having said that, we look forward to, because we want to know and understand that information. Transparency of data and information is something I think we think is a very important thing across the health care system, and whether that's the dashboard that we put up in December timeframe on payments in drugs, so that people can actually know which drugs have had the largest increase in costs, you know, creating that transparency for the consumer and providers, in terms of putting up on a website who are the largest recipients of Medicare payments, and so this is a whole space that we believe is going to improve quality and reduce price.

KENNEDY:

And thank you. And if I can, I've got about 30 seconds left. You touched based on your -- in your written testimony, as well, I think with Mr. Schrader and a couple other times, about the transition off of fee-for-service based systems in Medicare. I was hoping that you could provide just a little bit more detail on the learning and action network, how that's going, and what you see going forward, and if there's ways we can be helpful in 20 seconds or so.

BURWELL:

Important, thousands have joined, and it is a means by which the government in its changes in payment tries to align with the private sector, so we move together, we learn from each other, we get better results, and we prevent unintended consequences, and we're seeing that start to happen.

PITTS:

The chair thanks the gentleman. Now recognize the gentleman from Pennsylvania, Dr. Murphy, five minutes for questions.

MURPHY:

Thank you, and welcome, Madam Secretary. I'm going to run through a lot of statistics, but it's an important issue, because as we're trying to deal with the mental health reform legislation, one of the key issues is having more psychiatric beds, because of the IMD exclusion. We used to have 500,000 psych beds in this country in the 1950s, and now we have less than 40,000. We need 100,000, because people in an acute phase of a psychotic break need a place to go besides being

given a 5-point tie down in an emergency room or being sent to a jail cell or being discharged back in the streets, where they may have high risk of suicide, victimization, et cetera.

Run through a couple of things. The consequence of non-treatment of serious mental illness according to NIMH, even back in 2010, was pretty staggering, and they said that 40 percent of schizophrenics and about 51 percent of people with bipolar illness -- excuse me one moment -- thank you -- are untreated.

And a large majority of homeless -- excuse me, a large part of the homeless, about 200,000 or so living in abysmal conditions have high risk for other medical problems, and 28 percent of them get the food out of the garbage, so a high risk for a wide range of things. And out of those who are incarcerated, the seriously mentally ill make up 16 percent of the prison population, but almost 50 percent of the overall prison population with mental illness, high risk for other things.

But I wanted to go through some of these things, too. People with delusions and hallucinations, the longer they go without treatment, the worse it gets. The longer a person waits for treatment for a psychotic episode, the longer it takes to get their illness under control. For bipolar disorders, the sooner a person gets on lithium or other treatments, the better their treatment goes.

But what happens here is you have a wide range of people with serious mental illness with Medicaid, with SSI and SSD recipients, and the cost of untreated mental illness is pretty amazing. Direct costs that I see here for treatment of serious mental illness, about $55 billion, indirect costs, about $70 billion. And when you have added cost for emergency room care, private medical care, these costs go up considerably.

The cost of untreated diabetes in America is about $245 billion. That's $176 billion that's direct medical costs. And the reason that's important is many people with serious mental illness have a very high risk for diabetes.

Similarly high numbers are also there for cardiovascular disease, for pulmonary disease, for infection disease, all of which have a higher mortality and morbidity rate for the mentally ill. And you probably know that studies have said the mentally ill tend to die 25 to 10 years sooner, not because of suicide, but because of other medical complications.

So it goes down to this point. When we have asked the CBO to score the issue of what would happen if we looked at more hospital beds, they quite frankly admitted they couldn't do that, and they simply took a number, and the number of hospital days, psychiatric hospital days in America, and said, well, if we pay for them all, it's going to cost somewhere between $40 billion and $60 billion. In 10 years, we have no idea how to do this.

We really need your help. And I actually think this will be significant savings for Medicaid and Medicare if we get this right. If we figure out -- if we already know that people with serious mental illness are overusing emergency rooms versus caring for themselves, if we know that they have a higher incidence of those chronic illnesses I mentioned before, and we know that if they're not treated, it gets worse, it makes a lot of sense in dollars if we have hospital beds for them, and we have this acute illness, stabilize them, make sure they have outpatient care then, instead of doing

what we've been doing, and that is we traded those beds in the asylums for prison cells, for blankets on a subway grate, for the emergency room gurney and the county morgue.

So as we're going through this, I wonder if you've done any analysis here and can maybe talk about some direction that you're guiding CMS in, because we need solid numbers of what it costs to not treat and what it costs to treat. And I wonder if you could comment on that.

BURWELL:

So our estimation is that by 2020 the -- actually just the treatment costs for behavioral health and substance abuse will be $280 billion. And so that doesn't include even a number of the other things that you have talked about in terms about what this does as a nation. We agree and as part of our behavioral health proposal, the idea of getting those people into care -- our estimates are some of those people with severe issues don't get into care for three years, and that's about access.

MURPHY:

Three years?

BURWELL:

Yes. And so making sure that we have the ability for access when it is severe or even before it's severe is an important part of the proposal. With regard to our IMD proposal that Mr. Kennedy raised, I think if there are ways that we could be helpful in having conversations about how we solve those economics and how that was scored in terms of what we did, we'd be happy to do that.

And the other thing that I just think is an important part sort of putting on my old OMB hat so that we get to the place where we can understand how these things -- we spend money and what savings we get and that sort of thing -- is actually some of the money that we've asked for in this behavioral health money is about going ahead and doing the evidence-based work, evaluation, and I know many times people don't want to fund evaluation, but it is essential for the kinds of statistics that we need to show what you are talking about. But in the meantime, we can work on...

MURPHY:

Thank you. Let's do this, because I believe we can save a lot of money, and this committee really needs this, because, I'll tell you, there's bipartisan support, we've got to fix this problem to help Americans. Thank you very much. I yield back.

PITTS:

Chair thanks the gentleman. I recognize the gentlelady from California, Ms. Matsui, five minutes for questions.

MATSUI:

Thank you, Mr. Chairman. Thank you again for being here, Secretary Burwell. I'm glad you're here to highlight the ways that HHS plans to continue and expand critical investments in health and well-being of the American people.

The first step toward reforming our nation's health care system has been to improve access to health care by ensuring that everyone can obtain affordable health care coverage. We know that the Affordable Care Act has made great strides in that goal, and we must continue forward. We must also continue to be forward-looking and take the next steps in health care reform.

We need to continue to make strides to ensuring that everyone has access to the right care at the right time at the right price. I believe that there's great potential in the power of technology to help us achieve our goals of health care delivery system reform. Electronic health records can improve providers' ability to coordinate care and technology such as face-to-face video between providers and patients and technology that allows providers to remotely monitor a patient's chronic conditions can increase access to needed care, improve patients' outcomes, and reduce costs.

I was very pleased that this year's budget expands the ability of Medicare Advantage plans to deliver services via telehealth and enables real health clinics and federally qualified health centers to qualify as originating telehealth sites under Medicare.

Secretary Burwell, I am pleased with this progress, but I think there is still much more we can do. Can you talk a little bit about the inclusion of telehealth in the budget and any other proposals that HHS is currently considering in this space?

BURWELL:

So I think we think that telemedicine and telehealth is an important part of getting access. We've talked about access, and certainly in rural communities and other communities, this is going to be an important tool. And we've taken, too, as you articulated, very specific steps in our budget, because we think Medicare Advantage should pay, and because part of the reason that the field is not developing as much is because people don't get paid. So if you don't pay for the ability to do these services -- and that's part of the Medicare Advantage.

The other part is finding the facilities that will meet qualifications, so you do it in an appropriate and safe way, and that's the proposal that you mentioned, and it's relate to HRSA and our federally qualified health centers. We know that these health centers are serving literally millions and millions of Americans across the country, and most people actually have some in their district. And so that idea that you can use them as a base.

The other thing that we are working on right now is -- and it gets to Mr. Pallone raised in his earlier comments -- the issues of IHS, Indian Health Service. And right now we are suffering from a very serious problem on our reservations in terms of youth suicide. And in order to get providers in places like Pine Ridge, it's very, very difficult.

And so we are using our ability to actually use telemedicine as a means by which we can quickly get providers, because when you have these suicides, making sure those children have the support

they need, other children is -- you know, is a very, very difficult thing to do quickly, because we can't get the providers to go. And so while we're working on permanent solutions, these may become the permanent solutions, because they're stable.

Providers come and go, but the telemedicine providers we think will be in a place where they're going to provide more care for a longer term.

MATSUI:

Well, thank you very much. And I look forward to continuing to work with you on these issues. It's our shared goal to ensure that Americans have the ability to access the right care at the right time, and we must work hard to achieve that goal for the whole person, which includes access to mental health care. One of the goals of the delivery system reform is increased care coordination and behavioral health integration. We must ensure that people have access to a full spectrum of mental health services and that those services are integrated into medical care and coordinated across different providers.

I believe that the Excellence in Mental Health Demonstration Project, which I coauthored with my colleague, Congressman Lance, has the potential to reform our nation's mental health system by improving access to community-based care and by integrating and coordinating that care across different provider types.

Secretary Burwell, thank you for including in the budget an expansion of this demonstration project to six more states. The more we can test out this model, the better chance we have of finding out what works so we can expand it to those who so desperately need a better system in mental health care. Would you like to comment further on HHS's work on this project and its potential?

BURWELL:

Yes, we think it's a very important part of our work in terms of getting this integration and getting it quickly and doing it in a way that we can both get integrated care and also move to where it's -- where people are paying for value, not volume, in terms of getting the right payment to providers.

And I think you know that with your all's help and support, we've beat the statutory deadlines with regard to the implementation, and then we have added to that by the proposal in the budget, which we hope will be viewed favorably.

MATSUI:

Well, thank you very much.

PITTS:

The chair thanks the gentlelady. Now recognize the gentleman from Illinois, Mr. Shimkus, five minutes for questions.

SHIMKUS:

Thank you, Mr. Chairman. Secretary Burwell, thank you, and thanks for reaching out. We gave you a heads-up to talk about this CMS website thing. Of course, when you put something up, that means time, effort and energy was placed to prepare for this to actually happen. Of course, it was up, it was down.

So the basic question is, does CMS intend to go forward with this experiment?

BURWELL:

In terms of the...

SHIMKUS:

The Part D drug payment model?

BURWELL:

So with regard to this issue, I think as you appropriately reflect, this was something that came out ahead. With regard to the issue of high-cost drugs, which is what this issue is about, in terms of the potential Part D effort, what we've tried to do -- and this is to the point of getting input -- in December, we had a meeting that had both those from the pharmaceutical industry and other stakeholders to come and talk about, what can we do that maintains innovation...

SHIMKUS:

Yeah, that's different than having a proposed rule. And that's -- so what you did was by the CMS did, by shooting this publicly, is raise a lot of red flags. Is there going to be a rule? When is there going to be a rule? When are you going to notify Congress? And so that's why the questions.

BURWELL:

The questions, you know, in terms of speaking to the specifics of the rule, in this particular place, because things are market sensitive, have to be careful in terms of it, I think in...

SHIMKUS:

Their market -- that's why putting it up on the website, that's the market sensitivity to that, too, is just as bad.

BURWELL:

It was an error. It was an error, and I think we've very clearly said it was an error.

SHIMKUS:

But it was a premonition of future things to come.

BURWELL:

In terms of specifically speaking to what and when we'll do regulations, I want to be careful about that because of the market sensitivity. But what I think it's fair to say is, with regard to this issue, we will speak to it more in the future.

The issue at hand is in Medicare Part B, in terms of how the payments are done, they're done in ways where you as a provider as incented by a percentage, and that incentive is -- if you're going to be paid a percentage of the cost of something, then what we're doing is we're encouraging you to prescribe the larger cost item. And that's the substance of the issue at hand and why we are focused on it.

With regard to the specifics, we hope to have more soon on that issue.

SHIMKUS:

Good. Let me move to this issue on margins. The NIH states that the use of this is not appropriate means for controlling prices. So the question is, why haven't you all responded in this process, involved in the most recent petitions in this space and provide a sense of your -- the agency's current thinking on margins?

BURWELL:

We plan to respond to -- I think you're referring to the letter that I've received from a number of members in terms of the most recent questions. And we will respond to that letter.

SHIMKUS:

Because then, you know, the follow up is just obviously the R&D and the risk and return raises -- I mean, we need some clarity on this process.

BURWELL:

Yes, and I think it gets to the bigger issue, which is when I was starting is, the question of how we as a nation -- the high-cost drugs and the issue of drugs, when we look at Medicare expense and what we saw, the increases in '14 came from mainly high- cost drugs. There were some changes in other things. But in terms of that, and what percentage of our Medicare budget will be paid to drugs continues to grow. And so what we need to do is find approaches and strategies that balance both innovation, because we want that R&D to get the best things, but create some downward pressure, because I think whether it's people in Medicare or individuals who actually pay for their drugs in employer-based care, everyone is seeing the difficulty in both specialty drugs, but in also some cases non- specialty drugs.

SHIMKUS:

Because let me -- and my last -- let me talk about Medicaid for a second. Under current law, illegal immigrants are not supposed to get Medicaid. However, reasonable opportunity period exists. So the debate is going on in America is, why is there a reasonable opportunity period for illegal immigrants when there may not be -- in fact, there's not -- for citizens who don't have this, quote, unquote, reasonable opportunity period to prove that they qualify either through long-term care or because of their finances? And should that not be afforded to citizens the same as it's being afforded to illegal immigrants right now?

BURWELL:

I'm not sure. In terms of affording it to immigrants, are you referring to -- within Medicaid, immigrants aren't eligible, so the application...

SHIMKUS:

That's correct, but there is obviously some are getting -- there is a period of time in the law that requires -- there is a reasonable opportunity period, so there may be coverage for them to then either prove -- yes, they're legal or not. So then the question is, why it's not afforded to legal citizens based upon finances of long-term care?

BURWELL:

I think that the -- in Medicaid, it's applied both -- to any...

SHIMKUS:

Can you just check on that?

BURWELL:

I'll check on it.

SHIMKUS:

I'd appreciate it. Thank you.

BURWELL:

It may be the marketplace. It may be the distinction. So let us come back and find out, because Medicaid same, but maybe the marketplace. So let's come back if that's the question.

PITTS:

All right. Gentleman's time is expired. Chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, five minutes for questions.

SCHAKOWSKY:

Thank you, Secretary. I want to join in the congratulations to you on the Affordable Care Act, and while all of us acknowledge that there are some problems, it would be -- we've made such tremendous strides, and it would be wonderful if we could sit down and just fix the things that we could fix, make it even better.

I had a whole bunch of questions to ask you, but since July when abortion opponents released manufactured and highly edited videos, my colleagues on the other side of the aisle have been on a mission to undermine women's rights and apparently today isn't any different. But facts matter, and not a single claim made by the other side has been supported by a single shred of evidence. On the contrary, three congressional committees found no wrongdoing in their investigations of Planned Parenthood. The chairman in one of the committees investigating Planned Parenthood, Congressman Jason Chaffetz, went so far as to say, "Was there any wrongdoing? I didn't find any," when asked about his investigation.

I'd like to submit into the record, Mr. Chairman, a news article that includes this quote.

PITTS:

Without objection, so ordered.

SCHAKOWSKY:

Moreover, every state that has concluded their investigations into Planned Parenthood has come up empty-handed. In fact, a Texas grand jury ended up indicting two persons associated with the Center for Medical Progress, including its leader, David Daleiden, after their investigation uncovered illegal activity conducted by those individuals, not by Planned Parenthood. And I'd like to submit into the record another article detailing that indictment.

PITTS:

Without objection, so ordered.

SCHAKOWSKY:

And finally, just this week, the Washington Post editorial board published an article calling the so-called investigation, what I believe it is, a witch hunt, and not only do they point out that every state and federal entity that has investigated Planned Parenthood has found nothing, but the article also mentions the troubling document requests and subpoenas issued by the chairman of the select panel to attack women's health -- that's what we call it -- where I serve as the ranking member.

I'd like to submit that article into the record, as well.

PITTS:

Without objection, so ordered.

SCHAKOWSKY:

The relentless targeting of Planned Parenthood, the attack on women's health rights, and the disregard for facts have to stop. Here's what I want to ask you about this. Research using fetal tissue conducted by reputable universities across the country has greatly contributed to our understanding and treatment of many diseases. I know you mentioned some of this before, but can you describe the importance of fetal tissue research and the advances that have been made possible because of it?

BURWELL:

So a number of the advances, as I mentioned, hepatitis A, mumps, measles vaccines, in terms of that. And we also know that the research that is ongoing actually helps with issues around Down's, macular degeneration, and most recently we have seen it contribute to our ability to work on getting an Ebola vaccine. And so this research is an important part of the research in advancing science. And as I articulated before, I take very seriously the constraints and rules around the research at HHS and following those.

SCHAKOWSKY:

So there are definitely laws in place and regulations in place that make sure that this is done in what -- well, could you describe anything about the ethics of this?

BURWELL:

Two of the things that I think are probably the most important is no valuable consideration in terms of that. That has to do with the question of payment. And then the second issue is consent, and that's another issue that many states have laws about, but people -- you know, in terms of what people do, and I think those are probably the two most important that people on both sides of this conversation have focused on.

SCHAKOWSKY:

So you can verify that there is no ability to make a profit on the sale of fetal tissue?

BURWELL:

So with regard to -- and we have turned these documents over -- they've been requested of the NIH -- in terms of the attestations that our grantees have with regard to fulfilling the state and federal laws, both in terms of saying that none of those have occurred, and that occurs when the grantee is given, as well as at the point of renewal of grants.

SCHAKOWSKY:

Thank you. I also wondered if in the brief time I have remaining, if you could just say what impact has Planned Parenthood had on access to reproductive health services and what it means for both men and women if those health centers were to be closed?

BURWELL:

You know, I think it's both reproductive health services, but I actually think it's important to recognize that it is broader services, as well. So about 3 million women receive services across the country every year, it's estimated, and those services are issues also of wellness and cancer screenings and other things. So reproductive health is one element, but it is broader in terms of the basic health care that women are receiving from this organization.

SCHAKOWSKY:

Thank you so much. I yield back.

PITTS:

The chair thanks the gentlelady. Now recognize the gentleman, Dr. Burgess, five minutes for questions.

BURGESS:

Thank you, Mr. Chairman. And, Madam Secretary, I apologize that I wasn't available to take your call today. You called, I appreciated you leaving the message. I knew we would have a chance to talk today.

And at the outset, let me just say I've got so much stuff that I need to cover, and I recognize we won't get through it all, so I will submit some of this for your written attention, and furthermore because of the bill that repealed the sustainable growth rate formula last year and now the payment reform that is going on in CMS, and Dr. Conway has been very good about coming in and talking to me, but I really think the ongoing dialogue between HHS and the committee and members of Congress -- I mean, this will live on after this administration concludes and the next administration starts. And it's so important that we get it right, because this could form the basis (inaudible) for what payment reform really looks like, not just in Medicare, but with other payers, as well, and it's critical we get it right, because the whole purpose of doing the Medicare SGR repeal was we had too many doctors who were leaving the practice of medicine. SGR pulled the joy out of the practice. I think we're on the right foot now with getting this fixed, but it does have to be done correctly.

But a couple of things I do want to cover with you. Somebody already referenced part of the Affordable Care Act Section 1311(h), the part that deals with providers, it says that if I -- let me just read it, so I get it correct -- that under the quality improvement, which is section H of 1311,

beginning on January 1, 2015, a qualified health plan may contract with a hospital, and it goes through the parameters of B, a health care provider, only if such provider implements such mechanisms to improve health care quality as the secretary by regulation may require.

Now, can you understand why this makes many of the people that I interact with on a daily basis, the nation's physicians, can you understand why that makes them nervous? Have you begun to promulgate those regulations? Are those going to be new rules that we can anticipate? What is happening under Section 1311(h)?

BURWELL:

Is it under 1332?

BURGESS:

No, it's 1311.

BURWELL:

So I'll have to come back on 1311.

BURGESS:

OK.

BURWELL:

With regard to -- you know, we have done guidance under 1332. And I'm sorry, 1311(h) is not one that is a front burner, but we'll come back -- and I apologize, maybe I'll know it by another name, but I'm not connecting, so we'll come back on that.

BURGESS:

Let me move...

BURWELL:

1332, we have issued guidance on. That's the one I think that many people are raising on both sides, a lot of conversations about that one.

BURGESS:

Last summer, you addressed the National Governors Association, I believe, I heard it on C-SPAN while I was driving around in my district through the miracle of satellite radio. And Governor Fallin from Oklahoma asked you some questions because of the problem she has in Oklahoma

with prescription drug difficulties. She talked about a prescription drug monitoring program that she has developed in Oklahoma, but apparently Medicaid recipients fall outside of that.

And I think her question to you was, can something be done to mandate the same prescription drug monitoring requirements that she has under her state through the federal part of the Medicaid program?

BURWELL:

So I will have to go back, but I think with regard to the mandatory using of a PDMP, a prescription drug monitoring program, it is occurring at the state level. You probably -- all but one state has it in place. But it is done on a state-by-state basis in terms of having the physicians use it.

What we are trying to do -- and I just met with the governors on opioids, and the governors produced a really good document that I would recommend for folks to look at in terms of their recommendations around this. Many of the states I think are trying to advance that. What we're trying to do is share best practices. I called two times, have called all 50 states together so that we can get the right procedures that are happening in some states apply to the others. If there are things we can do, we welcome the opportunity to do them. I think it is a state issue, but we'll double back on that.

BURGESS:

But her specific request to you was she needed help in the Medicaid program because somehow it fell outside what she had available to her as a governor with under state law. And you know, I'll just say, speaking as a provider, I mean, we want to do the right thing. We want to be able to provide our patients who are in pain. We want to be able to provide them pain relief at the same time.

We want to participate in whatever diversionary prevention programs are out there, so it's -- this is extremely important to providers. I will just tell you, having been on both sides of that issue.

Let me in the brief time I have left, the issue of the unaccompanied minors. Of course, Texas, Low Rio Grande Valley sector, I've been down there several times, met with DHS, met with your people, with ACF and ORR. I will tell you, I am disturbed -- I'm also on the Helsinki Commission. And we had a hearing last fall in the Helsinki Commission where we heard from two victims of child trafficking. Both of these women were trafficked through family members, by family members, had come into the country illegally.

Granted, OK, they broke the law, but very compelling testimony of, you know, where was -- why was no one looking out for us? They were delivered to a family, which subsequently then put them into a sex trafficking situation. And there was no respite, no help for these individuals. And we've had so many people in the last two years, so many unaccompanied minors come across. And they've been placed -- you know, they produce a telephone number from goodness knows where, this is an uncle, this is a brother.

Look, many, many years ago, I went through a child adoption process. I know how intrusive and exhaustive that was. We're just sending these people off to a telephone number that they happen to produce out of their back pocket when they're picked up out of the river. I mean, and we wonder why now there are problems that are surfacing.

So, again, I ask for your help in interacting with your agency, ACF, and the Office of Refugee Relocation. We've got to do a better job in, you know -- yeah, I get the security side, and we've got to do a better job on the border, but if we also have a role for HHS with dealing with people who end up in the country, we've got to do a better job there. So I do welcome the opportunity to talk to you and the agency more about that in the future.

BURWELL:

Thank you. We take it very seriously. We want those children to be safe. We've made a number of changes. If there are other ideas, we have ideas from PSI on the Senate side. We'll be working to implement those. But if there are other things we can do, we've put in an 800 number. The background checks have been expanded. There are a number of things that we're doing, follow-up calls and that sort of thing. If there are other things that you see having been through that same process you described myself, you know, making sure you do everything you can to have children with safe people is something we think is extremely important.

PITTS:

Gentleman's time has expired.

BURGESS:

Thank you, Mr. Chairman.

PITTS:

Chair now recognizes Judge Butterfield, five minutes for questions.

BUTTERFIELD:

Thank you very much, Mr. Chairman. Thank you, Secretary Burwell, for coming today, and thank you for your testimony. I was present when you testified a couple hours ago, I guess it was, but thank you for coming, and thank you for the work that you're doing, especially your willingness to embrace the people of Flint, Michigan. You and I had a brief conversation about that last week, and I want to thank you publicly for your willingness to engage in that very sad situation.

Mr. Chairman, I want to go back to the issue of the Affordable Care Act. I know that's a subject that some on this committee have talked about endlessly, but I want to go back to it from my perspective and to continue to say that the ACA has made a positive difference for more than 18,000 constituents in eastern North Carolina, which is where I'm from, 18,000 constituents, more

than 18 million Americans who now have quality, affordable health insurance. That is by any definition progress.

But many Americans, including 700,000 in North Carolina, are still missing out on the benefits of the ACA, because our state governments have refused to expand the Medicaid program. It is absolutely a shame, and I will continue to say it every chance I get, it is a shame that 19 states in the United States have failed to expand Medicaid. They continue to block people from accessing health care funding, which they have paid taxes for and rightfully deserve.

I applaud the president's efforts to ensure that all states, regardless of when they decide to expand Medicaid, are eligible for 100 percent federal support for Medicaid expansion during the first three years of participation. Yesterday, Congressman Green, other Democratic members of this committee and I introduced legislation to codify the president's vision to incentivize Medicaid expansion. Also I appreciate the president's efforts to combat health disparities for African-Americans and other subgroups in the 2017 budget request.

The prevalence of health disparities is alarming, can be seen in all areas of health from access to care to susceptibility to illness to the lack of diversity in the health care workforce and in clinical trials. The 2017 budget includes meaningful investments which can help improve access to care for underserved communities, develop new cures for diseases, which disproportionately affect African-Americans.

And so as I close, Mr. Chairman, I simply want to ask the secretary one, perhaps two questions. At what point, Ms. Burwell, under current law will states that choose to expand Medicaid no longer be able to receive 100 percent federal support for their expansion? At what point do they lose it?

BURWELL:

At this point they would not start with 100 percent. So in terms of next year. And so that's why we've proposed the legislation, because I think we think it's important for any state whenever they come in to have that benefit of the 100 percent.

BUTTERFIELD:

And so it's your position and the president's position that this would help encourage the states to expand their program?

BURWELL:

We do.

BUTTERFIELD:

You call it incentivizing the states to do it?

BURWELL:

We want to encourage the states. And as I've said many times, and that same session that you heard, probably you heard me say to the governors, I want to work with you to do it the way that works for your state. And that means conversation one-on-one with every state, but we're willing to do that. This is that important. I'm personally engaged with every governor who wants to have that conversation.

BUTTERFIELD:

And I know you are. And I thank you for that. I yield back.

PITTS:

Chair thanks the gentleman. And recognize the gentleman from New Jersey, Mr. Lance, for five minutes of questions.

LANCE:

Thank you, Mr. Chairman. Secretary, last August, the Court of Appeals here for the District of Columbia circuit issued a decision interpreting the Federal Vacancies Reform Act that would prohibit various acting federal officers from serving in positions for which they had been nominated, but not yet confirmed by the Senate of the United States.

The Department of Justice filed a petition seeking further review by the entire D.C. Circuit, and that was denied. A Washington Post article recently covered this story and quoted the Justice Department in saying that the circuit court decision here in the District of Columbia casts a legal cloud over a number of acting government officials, and I think it's in various departments.

But your department was cited. Do you know, Secretary, who is in an acting position in your department subject to Senate confirmation who has not yet been confirmed by the Senate?

BURWELL:

I do, I do, because my deputy secretary for the department -- and I think you all know, we're having a budget hearing -- right now HHS is 25 percent of the federal budget. At HHS, it's over $1 trillion that we are managing. There is only one deputy at some departments. Other departments, there are undersecretaries, there are -- these are statutory constraints in terms of -- we have one deputy.

The deputy that we have that we have nominated, we cannot find in our records or in the records of the administration anyone who has not been confirmed or had a hearing for that...

LANCE:

Is that the only official in your department who is before the Senate?

BURWELL:

No, no, no, no.

LANCE:

How many are there -- how many are there, Secretary?

BURWELL:

I think it's actually important, though. This is an important part of the process of making sure that we can do -- you're an important oversight committee. And my ability to run the department well is about my ability to actually have people in place. The second person is Dr. Karen DeSalvo. Dr. DeSalvo has bipartisan support, has been voted out of committee, and has a hold because -- and hasn't been able to go to the floor because she has a hold.

LANCE:

There are two officials in your department...

BURWELL:

This has been ongoing for an extended period of time. We're working with our committee chairs, we're working with others on both sides of the aisle. But the question of our ability to...

LANCE:

No, I want to know how many there are. Are there two? Is that the answer to my question?

BURWELL:

That is the answer to the question who have been awaiting Senate confirmation.

LANCE:

And has your department reviewed whether or not this violates the Vacancies Reform Act, as has been suggested by officials in the administration?

BURWELL:

We work with the Department of Justice to make sure that we are in compliance. And we work with them, the Department of Justice...

(CROSSTALK)

LANCE:

And do you believe you are currently in compliance?

BURWELL:

We believe that our secretaries as they are in their positions are appropriately acting and work with the Department of Justice in terms of what will be the appropriate next step. But I think it actually is important, though. As a government, this question of our ability to function and the fact that not only that -- and I'm very thankful and appreciative that today I hope while we're in this hearing that Rob Califf will be confirmed for the FDA and thanks for the bipartisan support on that one.

But there are others, as well. In terms of two times we nominated a head of...

LANCE:

I have concerns about the fact that I think that all agencies have to follow the federal Vacancies Reform Act, and if a person has not received confirmation, there may be under the federal Vacancies Reform Act a cloud over that person's continuing in the office for which he or she has been nominated, not yet confirmed. Obviously, the Senate is an equal partner in the process of confirmation and initial appointment by the president. And I would hope that your department would review that.

Regarding medical device regulation, when are we going to have regulations regarding medical gas regulation? I'm very concerned about that issue, the lack of regulations, and lack of an approved label for medical gases has created confusion for both the FDA and the regulated community. And I believe this has been going on for four years. We would like to work with your department, and might you be able to discuss with us when the FDA could meet the statutory deadline for regulations that are supposed to be in place by July of this year?

BURWELL:

Look forward to following up on specifically where we are in terms of that specific regulation...

(CROSSTALK)

LANCE:

Very good. I think regulations have to occur by July, and I'm concerned that...

BURWELL:

And it's medical device?

LANCE:

Medical gas regulation.

BURWELL:

Medical gas. Thank you. Thank you.

LANCE:

Thank you. I'll yield back 12 seconds.

PITTS:

The chair thanks the gentleman. Now recognize the gentleman from New York, Mr. Engel, for five minutes for questions.

ENGEL:

Thank you very much, Mr. Chairman. Madam Secretary, welcome. And I too received a call from you, which I appreciated very much. I think it's just typical of your thoroughness and competency in the job you've done since you were appointed secretary. And besides, my mother's name was Sylvia, so I had to like you from the beginning.

BURWELL:

Thank you.

ENGEL:

I want to just piggyback first on a comment that Mr. Butterfield made, because it's something that's really been bothering me. I know that a lot of our friends on the other side of the aisle don't like the Affordable Care Act, and we voted 62 or 63 times to repeal it, which I think is a waste of time.

You know, any major bills of this substance in the past have always been tweaked once the bill comes out and you see what works, what doesn't work. Nothing's going to work 100 percent. And so if a bill is not doing everything we wanted it to do, we could make some legislative changes, and that's really the way to do it, not try to repeal it.

But our friends on the other side of the aisle refuse to do that. And what also is frustrating is, again, when governors are refusing to expand the Medicaid program, you know, my mother, Sylvia, used to have this expression that, you know, don't cut off your nose to spite your face. And that's exactly what the Republican governors are doing that have refused to expand the Medicaid program to really help the citizens of their states. So I'm wondering if you could comment on anything I've just said.

BURWELL:

So as we've spoken about a number of times in this hearing, I think it is so important to make that progress in terms of the coverage, in terms of the benefits that we can see through expansion, and

we see that both for individuals -- and I've had the chance to meet those individuals, as I've traveled across the country, in terms of what it means for them, whether it was someone being diagnosed with cancer and actually catching the cancer and being able to treat it, in terms of an extreme situation, or just the security of knowing that they have the coverage and can do prevention, as well.

But I think the economics are also equally important. That's about the individual, and that's important. But the economic issues in terms of hospital closures, in terms of uncompensated care, in terms of people's ability to pay their bills, are all things that are important consequences that we believe other states are already seeing the benefits from, and we'd like to see the rest of the states -- and as I've said before, willing to work with any state on the approach that they think is right with them. Just want to make sure we meet the standards that you all have given to us statutorily, which is making sure that affordable care is available.

ENGEL:

Thank you. I'd like to ask you a few questions involving Puerto Rico, because you had mentioned Puerto Rico before. You mentioned it in your submitted testimony. Could you please describe the current economic situation there and how it's negatively affected the health care system there?

BURWELL:

The economic situation is dire. And certainly my colleague at the Treasury Department, Mr. Lew, has taken the lead in terms of both our talking about that issue, as well as working with the Congress on fundamental issues that we think will make a difference to getting to a different place economically.

But the health care issues are very closely intertwined. And so the issues of legislation to help in terms of a way forward on the economics are very intertwined. The success of that is intertwined with health care. And it is because traditionally payments have not been equitable. And we talked about that, touched on that a little bit earlier in one of the questions in terms of the payments on the Medicaid side, and what that does is it leads to a number of things.

Obviously, it leads to coverage issues in terms of what kind of coverage people get. It also leads to provider issues, because providers aren't paid. And what we've proposed in our budget is a proposal that overtime would bring the payments in Medicaid to a more equitable space, and at the same time require reforms in terms of meeting certain standards of the performance of the Medicaid program.

So we think that we have a proposal before the Congress that can complement in an extremely important way. And I think right now with Zika, you know, the numbers continue to rise. Today this morning, I got my briefing, 111 cases, and in terms of the U.S., and in Puerto Rico right now, they are being spread by the mosquito there. And we know the penetration of both dengue and chikungunya in Puerto Rico. And so this health issue, if those children -- if pregnant women get Zika and have children with microcephaly, the cost is between $1 million and $10 million per child.

ENGEL:

So it's fair to say the situation in Puerto Rico is both an economic crisis and a health care crisis? That's for sure?

BURWELL:

It is fair.

ENGEL:

And the president's laid out what I think is a very reasonable approach to addressing the issues at hand, and I hope this committee will give the president's proposal serious consideration.

I want to ask you about your testimony. You described several steps the president has proposed to address the Puerto Rican crisis. Can you elaborate on his plan and what it does and how it aims to solve the problem?

BURWELL:

So I think that changes in Medicaid are the place where we have the most important proposal. It would do the changes over a period of time in terms of that payment. It would change the cap, as well as change the payment matches over the period of time, at the same time that reforms are required.

ENGEL:

And then my last question is, wouldn't you agree that Puerto Rico is a prime example of the tremendous risk we would face if Medicaid moved to a block grant system? Because of Puerto Rico's financing design, it's really not equipped with the flexibility it needs to adapt to financial downwards.

BURWELL:

Yes, which is why you see monies in the supplemental proposal that you'll be reviewing is a part of -- yes is the answer. And that's part of why you'll see funding in the supp, because now they have a crisis in Zika.

ENGEL:

Thank you. Thank you, Mr. Chairman.

PITTS:

The chair thanks the gentleman. I recognize the gentleman from Virginia, Mr. Griffith, for five minutes for questions.

GRIFFITH:

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

This morning, a new GAO, Government Accountability Office, report released found that 2014 CMS did not resolve inconsistencies related to incarceration status for about 22,000 applications, with 68 million in associated subsidies in the federal exchange. Some of these errors appear to have continued into 2015, and with unresolved inconsistencies, CMS is at risk of granting eligibility to and making subsidy payments on behalf of individuals who are ineligible to enroll in subsidized coverage.

CMS told the Government Accountability Office, quote, "The agency elected to rely on applicant attestations on incarceration status," end quote. In other words, CMS is literally taking criminals at their word and relying on them to tell the truth. I want to give you an opportunity if you're familiar with that, but based on that situation, you can understand I would suspect why Americans often don't trust the agencies to not cut corners on administering the ACA when they're not even going through and doing the due diligence according to the Government Accountability Office on making sure that folks who are incarcerated aren't receiving subsidies.

And, of course, I'm concerned about this as a 28-year criminal defense attorney before I came to Congress. A lot of these folks are not known for telling the truth, and you all are relying on just a statement from them that they're not really in prison.

BURWELL:

So with regard to this report, I think that this is a continuation of a previous study. And I apologize, but I don't think I have seen -- I think I've seen preliminary. And in terms of the recommendations in this in the preliminary, we fully agree with those.

But let me speak to the other -- with regard to the issue of making sure the right people are getting any of the taxpayer subsidies, we take it very seriously. Last year alone, 1.6 million people were taken off or had changes because we didn't have the information that we needed. That was done within a window, the statutory window that we've given, which is between 90 and 95 days, and we continued.

So 1.6 million people in terms of aggressively working -- we've put in place -- and when the GAO report originally came out -- and I think you know it was a secret shopper. So the actions that were taken by these individuals, if you weren't the GAO, would have been criminal offenses that...

GRIFFITH:

Yes, ma'am.

BURWELL:

... as you know...

GRIFFITH:

And I wasn't asking about that. My concern is -- and, look, I do understand, so I don't want anybody out there watching on TV to think that you should have already read this report, because I had an opportunity to read it while you were answering everybody else's questions.

But it is of concern that it doesn't appear that some of the folks who work for you are taking it seriously when the folks who show up on the PUPS list, the prisoner update processing system, you all have decided not to use that in the case of the Obamacare, but you are using it in the cases that relate to Medicare. You're using it for other purposes, but they decided not to use it in this case, and then they're just relying on somebody's statement that they're not incarcerated, and each individual is different. Some may not be in there for a crime of moral turpitude, but for some other crime, but as a general rule, a lot of these folks are in jail because they lied about something in the first place or took money when they weren't supposed to. And we're just going to rely on their word? I would ask you check into it. I know you haven't had a chance to read it, so I'm not saying that you should have a ready-made answer.

But I would say that you need to read it and you need to let us know, and we'll do it as a follow-up, if you would. When do you suspect or when do you expect these problems to be fixed? Again, not expecting an answer this morning, but would like to get an answer at some point in time.

BURWELL:

We'd be happy to. We have aggressively -- as issues are raised, we want to take care of them.

GRIFFITH:

I do appreciate that. I had some other questions which I will have to submit. I see my time's run out, and I don't even have time to finish the question, much less get an answer. We'll submit those to you afterwards, as well, but they relate to testimony previously in front of the committee relating to not giving the ability for states to have work programs as a part of the Medicaid and CHIP services, and we'll follow up with that afterwards, because like I said, it's a long question, and I don't even have time to get through it. But I do appreciate you being here today and always being willing to answer our questions.

BURWELL:

Thank you.

GRIFFITH:

And I yield back, Mr. Chairman.

PITTS:

Chair thanks the gentleman. Now I recognize the gentleman from California, Mr. Cardenas, five minutes for questions.

CARDENAS:

Thank you very much, Mr. Chairman.

In this committee, we've been discussing the consequences of not properly investing in mental health care. The problem of insufficient mental health care shows up in our nation's jails more than anywhere else in the country, particularly jails where kids are locked up. Federal law does not allow kids enrolled in Medicaid to receive federal funds while in detention.

But nowhere in the law does it say that these kids have to be kicked off of Medicaid, yet that is exactly what states are doing around the country. For them, permanently terminating Medicaid coverage is easier than suspending it temporarily. That's the states. When kids who already were on Medicaid are allowed to resume their needed access to mental health care services once they return home, the government saves millions upon millions of dollars each year when crimes go down, because these children have access to their mental health care instead of having to wait months and months and months to get back into the system.

Madam Secretary, can you talk about the department's work to ensure that kids who are on Medicaid can stay on the program once they're back on the streets?

BURWELL:

With regard to this issue, I think it's related to our broader criminal justice work and our second chance work that the president and the attorney general are both very focused on. We're working hand in glove with the attorney general and the Department of Justice to make sure that both with regard to Medicaid or the marketplace, that we both meet the standards that Mr. Griffith has talked about, but as well making sure that those who come out have the opportunities that they need with regard to having health care. And so it's across the board that we are working with the Department of Justice on it.

CARDENAS:

Thank you. Access to reproductive health care for women and families is very, very important. I'm glad to see that the president understands the value of critical reproductive health programs, like Title 10 and the Teen Pregnancy Prevention Program and Personal Responsibility Education Program. And that's -- it reflects in his budget proposal, as well. I'm glad to see that.

During a time where we continue to see attacks on the state level to restrict access to reproductive health, national investments in family planning, cancer screenings, STD testing, and sex education are more important now than ever to keep our families and communities healthy and safe. Latinos

in particular are more likely to experience higher rates of reproductive cancers, unintended pregnancy, and face added costs and language barriers to getting health care.

Secretary Burwell, could you talk about why it's important to invest in women's health? Can you share any information about efforts to target hard-to-reach populations?

BURWELL:

So the importance of the preventative services -- I think everyone knows that, you know, what the difference they can make, whether it's in the whole area of reproductive health, but women's health in general. Mothers often, they're the last to go in terms of take care of those preventative services. And so there are a number of things that I would highlight.

One is, the importance is that for all folks because of the Affordable Care Act, that there are free preventative services without co-pays, and so many people don't realize that and don't use those services, whether that is everything from your flu shot to some pre- cancer screenings.

I think particularly with hard-to-reach populations, one of the most important things that's happened over the last years is that the drop in uninsured in the Latino population is 4 million. So those 4 million people now have access to quality, affordable care. And that's step one.

Step two means, though, we have to take that coverage and make it actually care. They have the insurance and so doing that. And so some of the programs that you mentioned and some of that work is in CDC, and in terms of the Centers for Disease Control and Prevention, but we are working to make sure we're reaching those communities. We have something called coverage to care, which is an effort to make sure that people that get that coverage understand how to access a primary care physician, understand how to go about using the care, because many people -- it may be for the first time they have it and they don't know.

So it's about the insurance, but it's also about the care, and then it's about the public health issues that we're supporting and promoting. A Million Hearts, another one where there's disproportionate number in the Latino community who have heart disease, and the Million Hearts effort is specifically targeted towards heart disease.

CARDENAS:

Thank you for explaining what we are doing and what we should be doing more of, so thank you. I was one of those uninsured for a portion of my life when I was a child.

One way to make sure that we improve ourselves as a country is we need to pass the Each Woman Act and Women's Health Protection Act, two proactive bills that can turn the tide in the right direction. So, once again, thank you for doing what you can with the resources you have.

One of my colleagues mentioned what we're doing in ORR and what can -- my question is, what can Congress do? And are we providing you the services necessary to do the job that you need to do?

BURWELL:

We have a budget proposal with resources that we do need, so I hope that will receive consideration.

CARDENAS:

Thank you, Mr. Chairman.

PITTS:

The chair thanks the gentleman. Now recognize the gentleman from Florida, Mr. Bilirakis, five minutes for questions.

BILIRAKIS:

Thank you, Mr. Chairman. I appreciate it. Thank you, Madam Secretary, for coming. And also thank you for reaching out to us prior to the hearing, as well.

I have a couple questions. CMS recently released a final rule for the Medicaid covered outpatient drugs, but also requested comments on the definition of line extension drugs. As you know, there's a strong member interest in ensuring that any further Medicaid drug regulations for line extensions specifically exempt abuse deterrent formulations of drugs, such as opioids, to incentivize continued development of abuse deterrent formulations.

We believe CMS can do this under current statute. However, the budget includes a proposal to tweak the statute in this case. Is the budget proposal intended to clarify the law? Or is requested because CMS does not have the authority to clarify this administratively?

BURWELL:

We'd like statutory help with this.

BILIRAKIS:

OK. That's the answer I wanted to hear, because we can do that.

BURWELL:

We need the help. I think across the board this question of how we treat abuse deterrent drugs, the recent changes we just announced at FDA, how we're going to review opioids, new opioids coming to market, that we will actually consider the issues of addiction as part of the decision, not just is this drug safe and effective for an individual, these are important things. And I think they weren't necessarily always considered.

Where we have administrative authority, we're going to use it. Where we believe we need some help, we're asking.

BILIRAKIS:

Very good. Thank you. Thank you. Next question. In the December 2015 OIG report, the I.G. office stated that CMS could not ensure that the advanced premium tax credit payments made to qualified health plans issuers were only for enrollees who had paid their premiums. CMS did not have a process in place to ensure that the premium tax credit payments were made only for enrollees who had paid their monthly premiums and was relying on insurance companies to provide that information.

Does CMS now have policies and procedures in place to calculate premium tax credit payments on an individual level without relying on insurers' attestation and assurances?

BURWELL:

Yes. We historically were using the processes we used for Medicare, in terms of payments in that space, but we actually have gone ahead of that and starting in January it is on an individual basis. What that actually means -- and you can see that it's happening -- is the number...

BILIRAKIS:

This past January?

BURWELL:

This January.

BILIRAKIS:

OK.

BURWELL:

So in place and we've seen the results in that -- the number of those enrolled in the marketplace actually is lower, because we had more people come out, because we are reconciling with the issuers on a real-time basis, on a policy basis, instead of an aggregate basis, is the answer to your question.

BILIRAKIS:

Very good, thank you. Last question. On or about February 5th, CMS posted contractor instructions for a new demonstration that would test changes to the way Medicare reimburses Part B drugs. I know that Representative Shimkus touched on this, which currently uses the average sale price of the drug plus 6 percent. Those instructions appear to have been taken down at the

moment. What additional payment changes is CMS considering beyond the modifications to the ASP reimbursement rate? How will CMS select the drugs to which these additional payment modifications will apply?

BURWELL:

So with regard to that specific issue, it was an error went up. We will be coming up with follow up on that soon. I think probably the most important issue that CMS is considering in this space is actually in the budget, so it requires statutory change, and it is the issue of negotiating authority for the department with regard to specialty and high-cost drugs, in terms of ability for the department to negotiate. And so that's the most important one that when you ask what are we considering, we have -- a budget proposal -- and obviously now that is what the Congress in terms of its consideration.

BILIRAKIS:

All right, thank you very much. I appreciate it, Madam Secretary. I yield back, Mr. Chairman.

PITTS:

The chair thanks the gentleman. Now I recognize the gentleman from Indiana, Dr. Bucshon, five minutes for questions.

BUCSHON:

Thank you, Mr. Chairman. Thank you, Secretary Burwell, for being here.

The Affordable Care Act has resulted in about 30 million people still uninsured. Many -- in fact, the majority of people gaining insurance are through Medicaid expansion, which as a provider -- I was a heart surgeon before -- I can tell you doesn't guarantee access to the health care system, other than through the emergency room.

On the exchanges, deductibles are increasing, premiums are up, insurance companies are losing billions of dollars, and there are reports that the administration as was previously outlined by the chairman are illegally making payments to prop up the exchanges.

Non-exchange policy costs are skyrocketing, pricing businesses out of the marketplace. That's not my opinion. Just ask any business that's dealing with this. The 30-hour work-week requirements are hurting school districts, county governments, local governments on fixed budgets, resulting in loss of wages for their employees.

The meaningful use program, which, by the way, I'm a supporter of electronic medical records. We had them in our practice since 2005, but the meaningful use program in my view clearly needs pause, because there are significant problems with it, and the doctor caucus gave this opinion also to Dr. DeSalvo a couple weeks ago.

And the worst problem is the cost of health care is the biggest issue, in my view, and there's no significant effect on the cost of health care. Now, that is true, the payments through Medicare may be globally down, but the individual costs for services is actually continuing to rise.

I'm going to focus my question on the Healthy Indiana Plan 2.0, which is as you know Indiana's answer to covering low-income citizens which is a program that is working. Last month, Congresswoman Susan Brooks, Senator Dan Coats and I sent you a letter expressing our concern about CMS's decision to use what we consider a biased contractor to conduct a, quote, unquote, independent review of Indiana's Healthy Indiana Plan 2.0.

I know Governor Pence has been vocal about his concern with this second federal review led by a hired contractor that has a clear and documented bias against plans like Healthy Indiana Plan 2.0. Mr. Chairman, I have a letter from Senator Coats, myself and Susan Brooks that I'd like to submit for the record.

PITTS:

Without objection, so ordered.

BUCSHON:

I just wanted to reiterate that I think it's wrong approach, since the contractor is previously on the record of being critical of Indiana's model, and now is supposedly going to objectively help evaluate it. So I'm sure, as you know, under the federal acquisition rules, there establish organizational conflict of interest rules. In the interest of real objectivity, would you commit to sharing CMS's analysis of the contractors' adherence to those standards with the committee and myself?

BURWELL:

Congressman, I think in -- and I have responded to this...

BUCSHON:

You have, and I've read that letter. I don't have it on me, but I have read your letter.

BURWELL:

In that response, articulate that the individual that is mentioned in terms of the issue of conflict is not an individual that is part of the review. So with regard to that, with regard to the broader issue...

BUCSHON:

Well, that's different than our understanding, the governor's, myself, our senator, and a couple members of the Energy and Commerce Committee.

BURWELL:

Then we should go back. Our understanding of the individual that was mentioned in the communications that we've had, it may be...

BUCSHON:

Well, it's the Urban Institute.

BURWELL:

There's the issue of...

BUCSHON:

So how can CMS ensure the study is unbiased, given the Urban Institute's documented institutional bias against consumer- directed health care plans and Medicaid?

BURWELL:

First, we run our usual contracting process which you were referring to in terms of it is a separate contracting process, and Urban Institute does this type of work and has on a nonpartisan basis for years. The question of the bias was in reference to an individual that is not affiliated with this piece of work. And so maybe we have a misunderstanding...

BUCSHON:

Maybe we're at crosshairs there. But the governor, myself, Congresswoman Brooks, and Senator Coats didn't quite see it that way.

BURWELL:

So let's come back and try and understand if I'm talking about a different individual...

BUCSHON:

OK, I appreciate that.

BURWELL:

... or making sure we understand fully the issue.

BUCSHON:

Now, can you then submit to my office further clarification of that? I'd appreciate that.

BURWELL:

I will, absolutely.

BUCSHON:

RAC audits are an issue. And I know that was brought up. You know, both the contractors and in a couple different areas -- you know, hospitals have millions of dollars sitting on the sidelines waiting for after these audits, saying they've improperly been paid through the Medicare program. And I have a list of the things that are supposed to be happening with the RAC audits to make sure they're accurate and fair.

But I can just tell you that from a practical standpoint, this is a big problem, and they need to be reviewed further, whether or not they're in compliance on an individual case-by-case basis. For example, there's an issue -- and this is with Herceptin, which you probably know about, right. And I can tell you, my wife continues to practice anesthesia, and this is about multi-patient vials, so to speak.

And I'll submit that question for the record, because I'm behind. But the point is, in practicality, even though it says that you can use one vial for multiple patients, from a practical standpoint, for safety reasons, liability reasons, that's difficult to do. So I'll submit that question, but that needs to be reviewed.

BURWELL:

And I think we've reached out to make sure that we get the information from your staff on those specific examples, and we'll follow up.

BUCSHON:

You have, yes, thank you. I yield back.

PITTS:

The chair thanks the gentleman. That concludes the questions of the members present. We have time for one follow up on each side. Chair recognizes Ms. Castor for a follow-up, five minutes.

CASTOR:

Thank you, Mr. Chairman.

Mr. Chairman, I want to compliment you for having this hearing today, because I also serve on the Budget Committee, and unlike the Budget Committee, where there was a break with decades of tradition in not inviting the OMB director to come before the committee to discuss the administration's budget, you understand the importance of having this dialogue and the ability to

have members of both sides of the aisle ask questions. So, thank you very much for holding the hearing today.

And it's really too bad that the Budget Committee did not have that opportunity, because I order to tackle the long-term debt that faces this country, it's going to require bipartisan solutions. The CBO, the Congressional Budget Committee projects that the debt increase over the 10-year window will mainly be attributable to the aging of the population and its connected health care costs and Medicare and skilled nursing.

The number of people who are at least 65 will increase by 37 percent by 2026 from 48 million Americans to 66 million Americans. That's going to call on Medicare and skilled nursing like never before. So we have got to work together to tackle these issues.

And the problem with the Republican budget that has come out of the Budget Committee and then passed on the floor in the past few years is that those fundamental overhauls, such as block granting Medicaid or turning Medicare into a voucher, simply shifts the cost to Medicare beneficiaries, families, and states. And those are overly simplistic solutions that are not going to work for American families and it's not going to give us the opportunity to make the reforms in Medicare that are necessary to tackle the long-term debt.

So this is difficult. This requires bipartisan cooperation. There's no silver bullet. Madam Secretary, I'd like to ask you here at the end of this hearing and after a few years in your job and as OMB director, what gives you hope in reform? Is it prescription drug reform, the accountable care organizations, payment reform? What do you recommend to us to work on in a bipartisan way to tackle the tough long-term debt issues driven by the aging American population?

BURWELL:

So I think that what gives me energy and gives me hope is that I believe we are at a transformative time and that the energy that comes macro that was passed was actually in terms of what you all passed and gave to us to implement is tighter constraints than we even had before in terms of the rules and the changes and how we'll push through change. And so we're working very hard to implement it.

And so those types of things are extremely important. But what's happening right now, whether it's in the private sector or the public sector, whether it's the issuers and insurers or private companies, large self-employed companies, they are ready to make the change, because we all can't afford health care at these prices. And so it's not just about Medicare, it's not just about the marketplace. I was thrilled to hear of the commitment on delivery system reform and -- because for me, that's probably the most important thing I can do in the next 10 to 11 months. It's actually under 11 months now, is make sure that we put in place the changes. Some of that has to do we talked about the data and the data blocking and getting the help we need there. Some of it has to do with the support for the expansion of ACOs, the bundling, some of these other issues, understanding where we can make it better in terms of some of the oncology stuff we heard today.

But that working in partnership is what I believe will make the long-term difference. And the other thing I think is extremely important, that this is owned by the Congress, as well as the executive branch, because I think that will also make sure it is done in a way that is consumer friendly and consumer focused, as well as getting the change throughout the country, and it's not just about CMS or providers or insurers, but we can make it a broad change for the country.

So I am optimistic. This is hard. But I believe we're taking some of the steps that we know are going to get us there.

CASTOR:

Thank you very much.

PITTS:

The gentlelady yield backs.

Madam Secretary, as we have discussed on the phone in hearings, several occasions, the California Department of Managed Health Care issued a directive mandating that all plans immediately include coverage for all legal abortions, and this has resulted in pro-life churches, schools being forced to pay for abortion coverage in their health insurance plans. And this action by California is a direct violation of the Weldon amendment, which your department is tasked with enforcing.

Last year, when you testified before us, you said, quote, "We have opened an investigation in the Office of Civil Rights at HHS to investigate. We take this seriously. We're trying to move through the investigation as expeditiously as possible," end quote.

Now, this directive was issued 18 months ago. The investigation was launched 15 months ago. Still, no corrective action has been taken. So here's my question. First, would you consider this to be an expeditious investigation? And secondly, what specific details about the investigation can you provide? What steps have been taken? Why has this matter not been resolved? And will you set a date by which corrective action must be taken?

BURWELL:

Mr. Chairman, as you know, when you called -- actually, originally before the investigation started -- it was -- yours was one of the calls. There are a number of your colleagues that called. There were two or three colleagues that called.

When you all had called at that point, I talked to OCR, and we opened the investigation, because I take seriously the issues that you've raised and we are going to continue it. The investigation is open. It is not complete. Is it expeditious? I would like for it to have moved more quickly than it has moved, but the investigation is open. And until it is closed, I'm not at a place to discuss in terms of what the investigation has yielded or will yield.

With regard to the issue of timing, you know, as I said, I am not satisfied with our speed, continue to work on that issue, but don't feel I can give you a specific timeframe, because it is an investigation and I need it to run its ability and its course.

PITTS:

Thank you. I'll yield to Dr. Burgess.

BURGESS:

Thank you, Mr. Chairman. And I'll just take 30 seconds.

The issue -- and you talked about an engaged patient, Commonwealth Fund talks about an activated patient. Consumer directed health plans, HSA-type plans can help with this. There is the availability of a Medicare MSA, but it's impossible to find one. Nobody at 1-800-MEDICARE knows anything about them. No place on your website at Medicare.gov can you go and get information on a Medicare MSA. My feeling is this is something that -- where really you could involve the patient in helping to control cost and payment reform and product delivery.

So we really do need to work on this. It's to some extent available since 1996. But they're just vacant on the website.

BURWELL:

It's not one I'm familiar with, so I'll check and follow up and see where that stands. We'll get back to you.

BURGESS:

All right. Thank you.

PITTS:

Yield back. The concludes the questions that we have today. We will have follow-up written questions. We ask that you please respond, and I remind the members they have 10 business days to submit questions for the record. So they should submit their questions by the close of business on Wednesday, March the 9th.

Again, Madam Secretary, you've been very patient and very forthright. Thank you very much for coming. A lot of good information here today.

Without objection, the subcommittee hearing is adjourned.