Hearing Transcript

Senate Appropriations Subcommittee on Labor, Health and Human Services and Education Hearing on President Obama's Fiscal 2017 Budget Proposal for the Health and Human Services Department

March 3, 2016

BLUNT:

Good morning. Thank you, Secretary Burwell, for appearing before the Subcommittee today to discuss the Department of Health and Human Services' FY2017 budget request. We look forward to hearing your testimony.

We have many shared priorities in this budget proposal –
cancer research, combatting opioid abuse, and increasing access to mental health care. However, I was disappointed that many of these important investments were not part of the discretionary budget request to be considered by the Appropriations Committee

I was disappointed, however, that many of these investments are not part of the discretionary budget request, something that we want to talk about today -- I at least want to talk about today.

This is a precarious position, I think, for the department to be in. The request leans heavily on new mandatory spending proposals that bypass the current budget caps and bypass the discretionary allocations in the committee.

If the committee would follow of the recommendation from the department, we would cut almost $2 billion for programs currently funded by discretionary spending in this bill and would expect -- I guess, you would expect and the administration would expect new currently unauthorized mandatory funding to fill those holes. One thing if that happens, another significant thing if it doesn't.

My view would be that we need to figure out how to prioritize that everything can't be a priority. And so, this should be a discussion between us, on the committee, and with you as to what really -- where we need to allocate the money we have to spend in your department. It seems to me that the department submission just assumes it will solve this problem by mandatory spending and new resources that I have no particular reason to believe that the Congress is likely to agree with.

The subcommittee needs to look at what you suggested, look at the cuts would happen. If we just simply would adopt your budget, we -- for instance, with discretionary spending, we eliminate children's hospital medical education dollars that would theoretically come from somewhere else. But if we assume that's gonna happen, there would be no graduate medical education and children's hospitals. The administration's proposed funding increases can only be achieved by mandatory increases.

My overarching concern is that whether the department would truly be prepared for the budget you submitted if those mandatory programs don't happen. And I think it's something we should all be very thoughtful about because once we get through this process and those don't occur that would mean $1 billion cut in the National Institute of Health. It would mean, as I just suggested, no money for graduate medical education at children's hospitals. So I don't agree with the approach, but maybe you can assure us as to how that approach is going to have more success than I think it's likely to have.

But I do want to complete my opening remarks by saying I think you bring great capacity to this job. I appreciate your openness to discuss these and other issues not only being here today, but you've really been extraordinary reaching out to talk about the challenges that the department faces, and look forward to continuing that discussion.

I'm pleased now to recognize Senator Murray for her opening comments.

MURRAY:

Thank you very much, Mr. Chairman. And Secretary Burwell, thank you for being here today and for all that you do everyday to improve the health and well-being of our families and communities across the country. I look forward to your testimony today and the discussion about the departments funding needs for the fiscal year 2017.

While I know you are to be highlighting the department's request in your statement, I do want to note how pleased I was to see that it proposes a significant increase for early learning and child care and that includes $161 million to implement the safety and quality improvements that were contained in the reauthorization of that Child Care and Development Block Grant, which the Senate approved 16 months ago with overwhelming bipartisan support, 88 to 1, due in no small part to the leadership of Vice Chairwoman Mikulski and I. Thank you as well for that. Those investments really support working families and help make sure kids start kindergarten ready to learn.

I was also pleased the budget maintain support for the Affordable Care Act, which has expanded health insurance coverage to millions of people and helped a lot more families pay less for better quality care. We need to keep working towards more coverage not less, more affordability not less, and better quality not less, and that's something I know that on the site Democrats will continue to be focused on.

Overall, there is much to like in the president's HHS budget request. It builds on the bipartisan spending bill that Congress passed late last year, a bill that was possible because Democrats and Republicans were able to come together and break through the gridlock and reach a budget agreement that allowed us to provide needed discretionary investments in NIH, CDC, working -- worker training, childcare, early learning program assistance, to name a few.

That agreement show that once again when we work together to find common ground we can deliver results to the families and communities we serve and I'm hopeful that we can build on last year's momentum. Let's do the same again this year.

Many of the challenges facing us remain the same as when Secretary Burwell testified before the subcommittee last spring. There's still much more we need to do to continue the work started in the Affordable Care Act to expand access to quality, affordable healthcare. The intense competition for NIH grants means that fewer than 20 percent of applications get funded leaving lots of promising science without support and the epidemic of opioid and prescription drug abuse continues to hurt families and communities nationwide.

Secretary Burwell, as you well know, our broken mental healthcare system is yet another ongoing challenge we have to tackle. I know this is a priority that many members here today as well as in the health committee share and it is a focus for the administration as well. So I'm very hopeful that the bipartisan momentum we're seeing on this can continue and that we can work together on some solutions that expand access to quality effective mental healthcare so many families are struggling to find. We'll be challenged to find ways to address these and other persistent needs while also taking into account the new policies laid out in the Every Student Succeeds Act that Senator Alexander and I helped write, signed into law on December.

As everyone here knows, the two-year budget agreement rolled back the automatic cuts and allowed us to restore key investments but it didn't go as far as many of us had hoped. That means, as it often does, the difficult choices will be unavoidable in 2017 as they were last year. Even so, I believe that our subcommittee can find a way to write a bipartisan bill once again but doing so depends on this subcommittee getting an allocation that will allow us to make the needed investments in education and medical research and drug treatment and support for working families and a lot more.

I know Chairman Blunt would like to work on this bill in a bipartisan manner as well and build on the progress that we've made. So I look forward to working with you, Secretary Burwell, and all of our colleagues who are here today in the coming weeks and months.

Thank you very much for being here.

BLUNT:

Thank you, Senator Murray, and we do hope to be able to work on this bill together. Secretary Burwell, again, we're delighted you're here and we look forward to your testimony.

BURWELL:

Thank you. Chairman Blunt, Chairman Cochran, and Ranking Member Murray and Ms. Mikulski as well and all the members of the committee, I want to thank you for this opportunity to discuss the president's Department Of Health and Human Services budget for this year.

As many of you all know, I believe that all us share common interests and that we can find common ground. In the last legislative session, this Congress made timely investments in programs to improve the health and welfare the American people, and I thank you all and this committee for that.

The budget before you today is the final budget for this administration and final budget. It makes critical investments to protect the health and well-being of the American people. It helps ensure that we do our job to keep people safe and healthy, accelerate the progress in scientific research and medical innovation, and expands and strengthens our healthcare system, and it helps us continue to be responsible stewards of the taxpayers' dollars.

For HHS, the budget proposes $82.8 billion in discretionary budget authority. Our request recognizes the constraints in our budget environment and includes targeted reforms to Medicare, Medicaid and other programs. Over the 10 years, these reforms to Medicare would result in savings of $419 billion.

In order for Americans to benefit from recent breakthroughs in medical science, we need to ensure that all Americans have access to quality, affordable healthcare. The Affordable Care Act has helped make historic progress. And today, more than 90 percent of Americans have health coverage, the first time in our nation's history that this has been true.

This budget seeks to build on that progress by improving both the quality of care that patients receive, spending our healthcare dollars more wisely, and putting engaged and empowered individuals at the center of their care. It proposes investments to improve the access to care for underserved groups across the United States including many living in rural communities.

With $5.1 billion in health center funding and nearly $14 billion over the next decade proposed for our nation's healthcare workforce, even more Americans will be able to get the care they need. By advancing and improving the way we pay doctors, coordinate care, and use health data and information, we're building a better, smarter, healthier system.

Let me turn to an issue being -- I've been working on here at home and abroad as we work aggressively to combat the spread of Zika, the administration is requesting $1.9 billion in emergency funding including $1.5 billion for the Department of Health and Human Services. We appreciate Congress' consideration of this important request as we implement the essential strategies to prevent, detect and respond to this disease.

I know the rise is opioid misuse, abuse and overdose has affected many of your constituents. Everyday in America, 78 people die from opioid death. That's why this budget proposes significant funding, over $1 billion, to combat the opioid epidemic.

Research shows that early learning programs can set a course for child's success throughout his or her life and that's why over the course of this administration and together with congressional support we have more than doubled access to Early Head Start and services for infants and toddlers. Our budget proposes a total of $9.6 billion for the Head Start program and investment in child care services that would allow us to serve over 2.6 million children.

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.

While we invest in the safety and health of Americans today, we must also relentlessly push forward the frontiers of science and medicine. This budget invests in the vice president's cancer initiative. Today, we're entering a new era in medical science. And with the proposed increase of $107 million in the Precision Medicine Initiative and 45 million for the administration's BRAIN initiative, we can continue that progress.

Finally, I just want to thank the employees of HHS. In the past year, they've helped with the Ebola outbreak in West Africa that helped millions of Americans enroll in health coverage and they've done the quiet day-to-day work that makes our nation healthier and stronger and I'm honored to be a part of their team.

As members of this committee know, I'm personally committed to working closely with you and your staff to find common ground and deliver impact for the American people. And with that, I welcome your questions.

BLUNT:

Well, thank you -- thank you, Secretary, for your comments. We'll have time for a second round of questions. So with the exception of Chairman Cochran and Senator Mikulski, I'm going to run a pretty tight clock here and then we -- and they can but what talk as long as they want to, but we will then have time for second round. And so, hopefully, we'll all think about everybody else's time and I'll try to limit my own time in exactly the same way.

Well, what about the question I suggested in my opening statement, Secretary Burwell. What if you get the budget you asked for and the mandatory of things you hope would happen don't happen? What would you have to come back and ask us to do that would not be -- not be happening if you got your budget and the mandatory supplements don't occur?

BURWELL:

So, as we put the budget together, we put together as a budget. And we put it together in terms of what we think are the right need and the right trade-offs. And I think it's important to reflect that the mandatories that we proposed are paid for. And when we look at the issue of discretionary funding as we think about discretionary...

BLUNT:

That you paid for out of non-existing -- non-current resources of revenue, right?

BURWELL:

I think we proposed the revenue choices and other choices in terms of cuts. As I said, there's $419 billion on Medicare savings that we have and there are bunch of other things that we put in our budget to do the appropriate savings. And when we put forth a budget, it is about choices.

And within our budget, we made the choices that we think we should make. And I think it relates to the issue of the overall level of discretionary funding. That is something that I think when -- in the world that we live in where we have issues like opioids, behavioral health, the research that we all want to that when we think that we're going to end up in a place where our discretionary spending as a percentage of GDP is at some of the lowest levels we've ever seen as a nation and is that where we want to be. And so, we wanted to make sure that we are abiding by the deal but also reflecting what we believe are the right choices in terms of that spending.

BLUNT:

The -- but the mandatories paid for out of tax increases that the Congress would have to approve, is that right?

BURWELL:

I think there are numbers or combination of things throughout our budget in terms of the things that are in our budget. Some of those are revenue issues, but other things are on the other side in terms of some of the Medicare savings. And in addition, there are other things in are budget alone -- and some may bring this up -- we've actually cut spending on a number of things in terms of programs and its not a popular cut that we do, but we cut funding in terms of the CDC and vaccines that we believe are now being taken care of through the Affordable Care Act because people have that coverage and there's lower demand on this programs. And so, we put together a combination of things to pay for those investments that we believe are necessary for the country's health.

BLUNT:

And on opioids, we increased spending last year by almost 300 percent. I think we got slightly above the number that you asked for. I think we went for about $31 million or $32 million to $123 million, which was a big increase. I think your proposal here is $1 billion more moreover to?

BURWELL:

Yes. Yes. It would take us to $1.2 billion. And I think in the area of opioids it is related to an issue that I know you have been an incredible champion on which is behavioral health. And we all know that the issue -- one of the issues around behavior health is that was actually paid for at the state and local level.

And in terms of the capacity -- so one of the things it's most important in a strategic approach for opioids is medication-assisted treatment and that needs to occur on the ground in the communities and states like our home state of West Virginia but all across the nation. And so, the idea that we're going to be able to provide the capacity for treatment for the numbers of people we have is why we propose the increase that we have. The vast majority of the increase that we propose in opioids is for medication-assisted treatment that will go to the states and local communities.

BLUNT:

Just to help us make that case a little better as we discuss it, what's your view of what's happened that we have -- this is a problem that was a problem we were allocating $31 million to 18 months ago to one that now we'd be looking at something in the neighborhood $0.5 billion a year to...

BURWELL:

I think it is the demand and the need. When 78 Americans are dying everyday, I think we are at a point where it is a crisis in our nation and I think we're feeling that. And I think what we've done -- I think you know when I got to the department I asked for an evidence-based strategy to build on the work that we have been doing with very specific areas of focus that could have measurable results with regard to the reduction in the number of addictions and a reduction in the number of overdoses and a reduction in the number of opioid deaths.

That strategy had three parts to it and one of the parts is costly, but I think the more conversations we have -- I know you all are having them with law enforcement officials -- that they have become the healthcare and social services system. And so, we have to have a place where they're supposed to go and we have so many of them now that the needs are great.

BLUNT:

Senator Murray?

MURRAY:

Mr. Chairman, I know that the vice gentleman has to leave to go chair another committee. So, I'm so happy to switch spots with him at this point (ph).

MIKULSKI:

Thank you, Senator Murray. There's a lot going on today in addition to the Labor HHS hearing with this fantastic attendance. CJS will be meeting in 30 minutes and also milk (ph) on VA is also meeting. So I want to thank Senator Cochran for really mandating such a quick paced schedule that we have our hearings and do our job and look forward to again working with both he and Senator McConnell to follow the budget agreement, get our 302B and get going. So thank you very much for your leadership.

Secretary Burwell, we do want to thank you for your leadership and the way you've run the department. I think you brought stability, I think, to the workforce, conference in the Congress. Your responsiveness to us, I think, is a very much appreciated.

As we look at the President Obama's last budget, we know that what your agency does, with that 73,000 people, it touches every aspect of American lives and we need to be able to do what we need to do to really be able to help American lives. I have to my right a champion of NIH, so many of us are here, the chairman, the vice chairman of this committee, with NIH. We have to recognize that the defense of the needs of our country aren't only in the defense department and this is why we need to look at domestic discretionary spending and maintain parity with those two.

Well, let me get to my questions. Senator Murray and I conferred, she will be asking a lot of the questions that I have in mind like the opioid issue, the early childhood issue, and so on. Let me get to the Zika supplemental. The chairman raised the issue of his concern about mandatory funding. I'm concerned about that too and what could get cut. But you know, we just had a robust debate yesterday on the supplemental on opioids offered by Senator Shaheen. You have here before us the Zika supplemental.

I'm concerned that we just don't have enough to meet the emerging needs of our country and with the Zika supplemental, one, is it a big threat; and number two, why can't we use the money that's been left over from old Ebola; and number three, is it that we really need to look at CDC in the same way we have to look at defense -- excuse me -- our preparedness for a bio attack, chemical weapons attack, and so on and we have to come to grips with the Zika supplemental.

I talked to Dr. Frieden, Dr. Fauci. We have Dr. Fauci, we're turning to him once again. We're grateful to have him at NIH, but he's grateful to have our help. So could you comment on the Zika supplemental and is this the way we're going to do government mandatory spending supplementals or do we need an appropriations that America can count and its secretary can count on?

BURWELL:

So with regard to that broader overall question of where cap should be for discretionary, wear my old had at OMB, and we can discuss and I certainly have opinions, but I will address directly the Zika question.

The issue of Zika, everyday I get a report and we have more and more people. We have now in the United States more cases confirmed of sexual transmission. And when we think about Zika and thinking about it overall (ph) level I think there are three very important things to focus on. One is pregnant women because while the disease -- and we are learning more -- that it can cause Guillain-Barre, which is a type of paralysis -- temporary paralysis, I think right now our most important focus is on making sure that fewer pregnant women get Zika and have the consequences of babies with very serious birth defects, microcephaly. So one, we need to protect those pregnant women.

Number two, there are many knowns and unknowns. Right now, as I'm sure, Dr. Freiden (ph) and Fauci have shared with you, we don't know the answers to how quickly this spreads in terms of whether or not it stays in semen for an extended period of time, how long that is. And so, right now we have to give guidance telling pregnant women to be extremely careful. We don't know what point in a time in a woman's pregnancy that had it has impact. There are many knowns and unknowns.

So the money we're asking for is to make sure we can do the research and prepare the homeland. Right now, Puerto Rico has cases that are transmitted in Puerto Rico, not travel related cases. So, with regard to the issue of Zika, the money and the needs are urgent as we prepare our southern states especially for the summer for a mosquito that can breed and a cup full water that is indoors and can bite four people in one meal. And so, we are working very hard and have a plan to do that. The funding needs to come and it is time sensitive.

MIKULSKI:

But why can't you use the money that's left over from Ebola? That's from my position?

BURWELL:

So with regard to the issue of the Ebola money. I think it's...

MIKULSKI:

In other words, why do we need supplemental?

BURWELL:

So, with regard to the issue of the Ebola money, I think it's important to reflect that the moneys that are left are for very important things. After -- in Sierra Leone, after it had been declared transmission free, 48 days later we found another case of Ebola on a dead body because we were still swabbing, testing the dead bodies. That's how we found it and that's how we didn't have another large outbreak in Sierra Leone. After we've been told, we didn't have any cases. This is a disease where we are not done.

In addition, a big portion of the money is for global health security agenda. That is the money the Congress gave us. You told us to put together five-year plans to make countries meet their marks before we would put the money out. We have worked with those countries. They have put together those plans and we are going to put the money out on a timetable.

It's important because right now in Nigeria there is a Lassa outbreak. Lassa is related to Ebola. It's not the same disease but similar. Last year, I didn't come to talk to you all about it, but we had the most cases of the Middle East Respiratory Syndrome, which is even quicker to spread respiratory outside of Saudi Arabia. It was in Korea. We were able to handle it because they were prepared. That global health security agenda money and those countries preparedness is our preparedness because we're only as prepared as that weakest link and we don't know where it's coming. MERS, we have had a case in Indiana two years ago. These are things that now we're in a world where it is our own domestic security that were concerned about.

BLUNT:

The Chairman of the full committee, Chairman Cochran.

COCHRAN:

Mr. Chairman, thank you very much. This is an excellent hearing. Madam Secretary, we appreciate your cooperation with us in reviewing options for the funding levels and the bills that come out of the jurisdiction of our committee. It's a big responsibility. It's a problem. States like mine, where we have a higher number of people who have a hard time getting access to and affording paying

for healthcare or the hospitals and doctors fees, education programs, there are a lot of places where we can do a lot of good in helping to make life more tolerable and enjoyable, and that's what really moves us, but we get tangled up sometimes in the procedures and forget what the big picture is.

But the money, for example, like critical access hospitals, I'm disappointed that the administration is not requesting more funding for those facilities where those facilities are less than 10 miles away from the nearest hospital. I hope we can look for opportunities to be more sensitive and generous and that means stretching dollars and providing the bulk of the money where people wouldn't have access.

So what is your response to that? Are we doing the right thing? Are we overdoing this? Are we denying emergency services for life- and-death situations?

BURWELL:

So with regard to the issue of critical access hospitals, I think it falls into the larger category of rural health in America and that's something I'm specifically focused on two because of where I'm from, in terms of being from West Virginia. And so, there are number of things our budget that we're doing to focus specifically on how we are supporting those rural hospitals across the country.

One of the things is our proposal on community health centers -- and thanks to all of you all for your support previously on this issue -- because as community health centers are disproportionately in the communities that we're talking about; 38 percent of them are in rural America. In addition, the proposal we have in front of us will increase the number of those with the same dollars from last year, but we will be able to increase the numbers.

In addition, our National Health Service Corps, 40 percent of the National Health Service Corps serves rural America and we've proposed to increase the number of people that will be serving there. In addition, our proposals and some of the proposal we were just talking about in the area of opioids are specifically targeted to rural America.

We also have some telemedicine proposals that I think will particularly help rural America. And I will say in many states the expansion of Medicaid has made a huge difference to hospitals. And what we see is that the majority of hospital closures, and especially those rural hospital closures, are closing in states where expansion hasn't occurred. There are many things that contribute. As we know, it's about providers. It's about population density. But we are already seeing those statistics. So those are a number things.

With regard to the specifics of the critical access hospital issue, I think we believe those hospitals will still receive disproportionate Medicare payments and we -- our analysis says that hopefully that will be something that can help them.

COCHRAN:

I appreciate very much your personal attention to that challenge. Thank you, Mr. Chairman, for providing this is increases that we are submitting in our committee.

BLUNT:

Thank you, Chairman. Senator Murray?

MURRAY:

Thank you very much. Secretary Burwell, I really was pleased to see that you requested $100 million increase for preschool development grant. As you know, the bipartisan ever since we (inaudible) for the very first time in our nation's primary education law authorize dedicated funding to improve access to preschool for children from low income and disadvantaged families.

Now, the full program will be funded at HHS, but it is to be jointly administered by HHS and the Department of Education. The Department of Education has done great work in collaboration with you to help states develop and sustain strong early learning programs. I wanted to ask you, how is HHS planning to take advantage of the expertise at the Department of Education with regard to its early learning programs?

BURWELL:

We plan to work on the relationship that we've had historically in this specific area in terms of how we jointly worked on it before when it was sitting in education as well as how we work on a number of issues and whether that joint letters in the space that the secretary of education and I do regularly in terms of when we want to communicate or do policy efforts.

And in order to make it so that it is more formal in terms of making sure that we are going to follow that path and that there's set parameters, we're actually working on a memorandum of understanding so that when the programs switches not in this fiscal year but the next fiscal year as directed by Congress, when it moves to us, there's a memorandum of understanding that will layout specifically the ways that we make sure that we ensure that we're getting appropriate input from our colleagues and run the program in a joint fashion.

MURRAY:

So you'll be working a lot of step (ph) with them...

BURWELL:

Yes. Yes. That memorandum of understanding is something we'll develop together so that would put in place processes are formalized because we want to build on what I think has been more informal, but we'd like to go and formalized it because I think we think that will help us make sure we succeed.

MURRAY:

Great. Thank you. As you know, there was a surge late last year in the number of unaccompanied children crossing our southern border and referred to the custody of HHS. Your department has used the resources the subcommittees has provided to find temporary bed space for those children should this trend continue.

Yet, at the same time, the Associated Press and the Senate Committee on Homeland Security and Government Affairs found that your department did not adequately protect these children after they were released to sponsors. Some of those children were victims of abuse and neglect and human trafficking. And in my view, HHS should be doing more than just finding bed space for these children.

Can you talk a little bit about what changes in policies that you've instituted since the stories came out that will help make sure that these vulnerable children are protected?

BURWELL:

Yes. The safety of these children is our priority. As you know, that is our role in this process. We are tasked with placing the children as quickly as possible in safe settings. We -- I think it's important to reflect that the PS -- the homeland security can -- when they were looking at is a case in Ohio. That is the case where people broke the law. And as soon as we had any knowledge of that, we started working with the Justice Department quickly to make sure that we work to prosecute to the fullest extent of the law for -- with those children and make sure it is an awful situation that should not happen again.

There were other accusations that a whistleblower made. We looked into them. Our IG has looked into them. Our IG found that there was no substantiating evidence that they had in front of them with regard to that. Having said that, we have put in more, what we consider, policies that will help address some of the issues to make sure were doing as much as we can.

One, any adults in the home where child is being placed will go through a background check. In any place where a child is placed in a nonrelative or a distant relatives setting, those places where we are going to work hard to make sure we're doing appropriate checks, some of those even in the home, and make sure we do home visits.

In addition, for anyone that is placed in a non-family member setting, there will be followup services. We put in place an 800 number for the children themselves if they have concerns so that they can reach out.

One of the things about the funding though -- and we had this conversation last year -- why we would actually like flexibility and the funding is because we don't know the numbers and they fluctuate. I think you all know it was 17,000 children in the first quarter of this year and we don't know. We have to make sure we'll have funding to get the children off the border and have the beds.

The contingent fund that we have proposed would allow us the flexibility to make sure that we know that we can provide beds but at the same time could think about other ways we can enhance

services. Right now, first call on the dollars -- right now, we're using and doing all of those things. I think the question of us doing more is related to funding.

MURRAY:

Thank you very much, Mr. Chairman.

BLUNT:

So the list I have, we'll start with Senator Alexander then Senator Merkley, Senator Capito, Senator Durbin, Senator Moran, Senator Shaheen, Senator Cassidy, Senator Lankford. Senator Alexander?

ALEXANDER:

Thanks, Mr. Chairman. Madam Secretary, first, let me thank you for the way you work with the committee and our -- with me and our office. It helps some of us here in the results business and a lot of them are on this committee and we like working with a secretary who works the same way, so thank you for that.

I've given you a letter about the so-called Medicaid bump up. I don't want to take my time with it here, but I would -- it comes from our entire delegation and I believe it may have -- there may be some unintended consequences from a well intended effort to encourage more doctors to see Medicaid patients. So if you would look at that, I would appreciate it.

BURWELL:

I will look into it.

ALEXANDER:

Now, Madam Secretary, let me -- I want to talk about -- one subject I want to ask for your advice and as much support that you can give to the -- give to the idea. This is an exciting time for science. We -- many of us believe that here. There's an opportunity to help million -- you know, almost every American with biomedical research. The president himself -- I mean the president is for a lot of things. But among the few things he's really for is his Precision Medicine Initiative and I know that and I talked with him about a year ago. I have attended his precision medicine events and I pledged to him that I'll do my best to help him create an architecture here in the next year that will put us on the path forward the precision medicine -- personalized medicine that he correctly talks about.

So the budget throws us a little curve. Senator Blunt talked about that. It's not surprising. I mean it happens every year really. I mean Army Corps of Engineers, you know, ordered to put money back in so the administration cuts it way back, but the idea that you would -- in the discretionary fund after we work very hard, Senator Murray, Senator Blunt, Senator Durbin, several others to have a significant increase in discretionary funding really to get on a path toward better funding for the National Institutes of Health if you could come in with a lower amount of money for -- in

discretionary funding with the hope that somehow some committee might authorize mandatory funding or past due taxes or something else that's not very encouraging.

So since we're in the results business let me suggest that a path forward -- and I'll try to so quickly you will have a little time to answer -- the most important legislation in the committee that Senator Murray and I share is our biomedical innovation legislation. It is companion to the House 21st Century legislation. We've talked about it many times.

We're moving really well on it. We have 50 proposals that are bipartisan and we hope by early April to have approved those in the committee in a bipartisan way and that's a train that should get to the station for the Precision Medicine Initiative, the Cancer Moonshot, electronic medical records, and any thing that has to do with mandatory funding for NIH.

The only way I can see you get that there is to improve -- is to approve these 50 proposals, most of them, that would be one vehicle. And a second vehicle -- and that would be bipartisan. I think we can do that. And the second vehicle would be a bipartisan consensus on mandatory funding.

I think about a little differently than just a big block of money. I want to see this committee continue to increase our discretionary funding. I'd like to see the mandatory funding not be a substitute but to be in addition, a surge of funding for such things as Cancer Moonshot, precision medicine, big bio think (ph), such issues like that.

I think we could agree on that, find a way to pay for it, and take those two bills to Senator McConnell, the 50 proposals, and the bipartisan or mandatory funding in mid-April. And if we do that, I believe he would put on the floor. I believe we would pass it. I believe the president -- I believe we could merge it with a House bill and the president would gladly sign it because it has so many things are important in the future of our country.

Now, my question is, will you help us figure that out, particularly with your budget background, and do you have any advice?

BURWELL:

So I think the -- we are completely aligned -- and I think you know and we had a conversation with the members of this committee -- about the idea and the work on the companion to 21st Century Cures here in the Senate and we're very appreciative for the work you all are doing, especially in electronic health records. I did an announcement on that as recently as Monday that I think very much aligns with the legislation that you all are considering unblocking.

And so, that whole range of substantive issues that you are focusing on I think we're aligned on. We want to continue to provide any technical assistance that we can and support for figuring out how you get a companion that could be conferenced. And I think it's great that you're focused on the issue and I know these are complicated issues, but the idea of mandatory funding as a means by which we can move forward on these incredibly important things you listed them, precision medicine, the issue of as we think through NIH, cancer, and I think it will also touch...

(CROSSTALK)

ALEXANDER:

... investigators perhaps.

BURWELL:

... and I think it will also touch on the BRAIN in terms of...

(CROSSTALK)

ALEXANDER:

Yes. Absolutely, the BRAIN initiative.

(CROSSTALK)

BURWELL:

... making sure. So I think what I pledge to do is work with you and the committee on figuring out how we can. I understand the tough questions on mandatory discretionary caps, how we do this. I think what I -- we want to do and we're excited to do is to work -- because I think there is agreement these are priorities for the nation. And so, how we can figure out ways to get that funding and to get the legislation because that's the other part of what you're speaking about on things like blocking, on things like making sure that we can do our investigations at NIH and more efficient ways. Those are all things that we're excited to work on.

BLUNT:

Senator Merkley.

ALEXANDER:

Thank you, Mr. Chairman.

MERKLEY:

Thank you, Madam Secretary, and thank you, Mr. Chairman. I wanted to raise two issues related to children's health. And one is a topic that probably had more discussions about anything else and it will surprise you that I wanted to check in on the on the deeming role of the -- and that concerns me so much is between 2013 and 2014, years of E-cigarettes by our middle schoolers and high schoolers have tripled and addiction to nicotine is a pathway to a lifetime of disease, huge impact on quality of life for children, huge costs healthcare system, and we have the potential to do it differently but the rule has to emerge someday. And while it's not emerging, more and more

children are being targeted by the fancy flavors, the candy flavor, so and so forth, and is there hope?

BURWELL:

Yes. In terms of moving the rule, I think you know it had 135,000 comments. A complex rule with a number of different pieces and parts to it, the one we're focused on E-cigarettes certainly I think the anchor portion of the rule. I would like to -- you know, it is something that we will move. I feel confident that this will occur with regard to the specific of the timing and then, you know, you will not -- I'm sure that I can predict that. I think, you know, I do this -- we do rulemaking in partnership. And so, we will continue, I think, you know, and you and I discussed my intents to make sure that we do that.

At the same time, a number steps have been taken in addition. And for the first time, we have actually done a no sale order on tobacco where we have providers who are not abiding by the regulations for the first time ever. We have said that there will be providers who because they have gone through a number of times of not abiding by the law that they can no longer sell.

In addition, I think you also know with regard to liquid nicotine that we have an NPRM that we're working on to continue to move forward. So there is that rule. There are other pieces that we're continuing to work on space.

MERKLEY:

Well, I know you have a lot of issues you're concerned about and this is when we do care about. I know it's out of your hands in terms of (inaudible) partnership your department and it's the potential for important healthcare and please stay at it as you as you have been.

BURWELL:

I will.

MERKLEY:

Thank you. Second, I wanted to turn to the HIV network. There is a group of 18 research sites that participated in the HIV research network. It was established in the year 2000. It collects data on 25,000 children, adolescents and adults with HIV from across the United States. And together, these sites provide unique source of information on the delivery, disparities, cost- effectiveness, the quality of HIV care, and it has helped to give a lot of insights about how we can address this disease more effectively. Oregon Health Science University is one of those 18 sites.

This this particular network is slated for elimination in the 2017 budget, which I think caught many of us by surprise. And so, I just want to check in with your team and my impression is that the valuable insights of tracking of this disease and the routes it is taking, and so on and so forth, has contributed a lot to the treatment and care management and I'm hoping you can take a look at it and see if we get your support to keep this network alive.

BURWELL:

I will look into this. This is one I'm not familiar with in terms of the change, so I will look into it.

MERKLEY:

Thank you. And I'll just a close with a comment. I appreciated the ongoing funding for the National Institute of Nursing Research. The NINR typically allocates about 7 percent of its budget to research training to help develop nurse researchers, servers, officers, future nurse faculty, which is a facing a growing shortage, and they sometimes are able to address some of the pieces that get left out of the kind of pure disease science cited, end of care of life, advanced directives, bedside of support, so on and so forth, palliative care. And I appreciate that but it does provide $146 million continued institute. Again, thank you.

BURWELL:

Thank you. Thank you.

BLUNT:

Thank you, Senator Merkley. Senator Capito?

CAPITO:

Thank you, Mr. Chairman, and welcome to the secretary, my fellow West Virginian. We're very proud of you in West Virginia. I think I said that last year and it continues to be so. So, thank you for a great representation and for your great communication with all us I think.

I have a couple of things quickly. President Obama came to Charleston, West Virginia to talk about the opioid issue. You put a lot of emphasis on it. You mentioned this medical-assisted treatment, greater emphasis in the budget on that, and some of its targeted towards rural areas. Am I -- am I correct in that?

BURWELL:

That's correct. That's correct. And we're already in our current funding that we have that you gave us last year. Our high communities with high need and many of those are rural. So, we're using existing funds to do some of that targeting as well.

CAPITO:

But the budget that was bumped up in December with, I believe, it was $100 million additional dollars. Are those dollars been spent yet or where you -- wasn't that the emphasis? I mean we're working a bill through the Senate right now that we want to...

(CROSSTALK)

BURWELL:

So with regard to that, those moneys are going against the three priorities that we've articulated. One is medication- assisted treatment. The second is making sure that we do the appropriate work on prescribing. And CDC I think you know is about to issue new guidelines. We want to make sure those guidelines get the right people. The third area -- and this is where money is moving right now is naloxone and Narcan. So when you get to that situation where a person has overdosed that we can try and save his life.

CAPITO:

On the prescribing issue, I've been working on an amendment to do have the protocol set up for acute pain. So if you have a toothache or something, what are the protocols for pain medications on that? Alzheimer's is another area of interest for me. As just formally being a family caregiver of both of my parents, it's emotionally challenging. It's very expensive. And I don't think the training is in place. What kind of arenas are you going into to try to help families and caregivers who not really train for this to meet this enormous challenge?

BURWELL:

So we have -- there's the money embedded (ph) at NIH which is research -- excuse me -- that's more focused on the science...

CAPITO:

Right.

BURWELL:

... which I think gets to a little bit of caregiver issues in terms of we're better able to do prevention and care for the individuals. But the piece of work in terms of the caregivers themselves is more the administration for community living. And last year, at the White House Conference on Aging, it's an annual -- it's -- I think it's every five years, maybe every 10 -- but last year's conference, we spent a lot of time -- and we actually did regional meetings across the country.

This was one of the issues that we focus on, both in terms of getting input for what would be the agenda when we came to Washington, D.C. but also trying to make sure that we're putting out as much information as we have as easily as we can. But it is a place where I will say I think we can do more and better.

CAPITO:

Yes. I would say definitely.

BURWELL:

More and better.

(CROSSTALK)

CAPITO:

I mean as the population ages, it hits every family. It's just very difficult. I think the BRAIN Initiative is terrific. I know West Virginia University is participating in part of that and I'm very pleased about that.

The other issue I wanted to talk to you about was hospice. And I'm not sure -- I think we've written to you -- we understand the need to audit Medicare providers. But some of our hospices are -- have a backlog of appeal to the Office of Medicaid Hearing and Appeals were hundreds of thousands of dollars. The local hospice and in my area, you're holding like over $1 million worth of the payments while they go to the appeals. That's difficult on a nonprofit organization that I think really has great services.

Is this a function of not enough administrative law judges or what is the backlog here?

BURWELL:

So there are -- the backlog that we have a Medicare appeals is related to a number of issues and it is related to administrative law judges. We'd ask for the funding. We've actually put together a three-part strategy to reduce the backlog. Number one is administrative actions that we can take to create a process that works more quickly. We've taken those steps. Number two, we have legislation. And on the Senate side, the finance committee actually has past portions of that legislative. We need statutory changes. It would be helpful to get that. And the third is money so that we can actually increase our numbers of administrative law judges.

CAPITO:

Have you asked for that in this budget?

BURWELL:

We have. We have.

CAPITO:

OK. And lastly, you've mentioned two or three times about $419 billion savings in Medicare. And when I was looking through your statement, I noticed that you refer to alternative payment models. What is an alternative payment model simply?

BURWELL:

So an alternative payment model is sometimes called accountable care organization and these alternative payment models are places where we pay for value, not for volume. And so, what that means is instead of paying for the number of services you pay for an episode of care or the result for the individual, and we do that in working with providers and insurers and others across the country.

The Center for medication -- Medicare and Medicaid innovation is where we do these demonstrations and experiments and we're already seeing results. We've seen over 400 million in savings in terms of these accountable care organizations. So they focus on you get the benefit if you get well people and you treat them for their wellness and the results versus service by service.

CAPITO:

Well, we have to have an extended discussion on that. It's very complicated. Thank you very much.

BURWELL:

Thank you.

BLUNT:

Senator Durbin?

DURBIN:

Thanks a lot, Mr. Chairman. Madam Secretary, thanks for being here. In this room at this table sits some people who have done some amazing things in this year's spending when it comes to medical research. And I give special credit, of course, to the Chairman and to Senator Murray on this committee, Senator Alexander on the health committee, virtually 5 percent real growth with the National Institutes of Health.

It is a shot in the arm and an encouragement to medical researchers that we are serious about our commitment to biomedical research. CDC similar in increases and I think CDC is our nation's first line of defense when it comes to national health security. We should start describing it as such because day in day out, year end and year out, that is their mission.

I was disappointed with the budget. I will accept Senator Alexander's analysis that sometimes your cut in the areas where you know Congress is going to step in and fill the void and I hope that's the case here. But what the chairman said at the outset, counting on mandatory spending to make up the difference is a risk I hope we never take. We should do our part of the discretionary side and hope, as Senator Alexander described it, that we can supplement that with some commitments on the mandatory side.

I just think we make a serious mistake -- and Dr. Collins told me as much as (inaudible) told you don't have constancy in our commitment to biomedical research, there's just a real question by

researchers as to whether they ought to take the risk and continue in the field if there is uncertainty about funding in the future. So, I'm looking forward to working with you and Senator Murray who bridges both committees, health and appropriations subcommittee, and Senator Blunt to achieve that goal.

I'd like to ask you for my -- on the issue of opioids and heroin, 80 percent of heroin users start with opioid prescription drugs. That's a numbers that's been repeated many times. I'd like to ask about two things. What is the responsibility of pharma when it comes to this current challenge? They are generating, I am told, 14 billion pills a year -- opioid pills enough to provide a one month prescription to every adult American. Clearly, they are flooding the market with product and that has to be part of our calculation about what we find ourselves in the position we're in.

And secondly, what are we doing in this world of pain management? I mean you and I talked about this on the phone, understanding that physicians have responsibility when it comes to pain management. Understanding is a subjective statement as to whether I feel good or I don't feel good. There is still I think -- there is a question that should be raised as to whether there is proper management when it comes to -- by the physician. When it comes to pain, handing someone 40 or 50 pills, as referred to testimony in other committees, is overkill in many instances in putting more pills out into the potential illegal market.

So, in those two areas, pharma's responsibility and the responsibility of physicians, what would you suggest?

BURWELL:

So with regard to pharma, I think two of the most important things that pharma can do right now is develop true abuse deterrent products for existing opioids and the other thing is they need to develop products for pain that are not addictive in terms of the research and the work that they need to do in these spaces at the same time making sure that in all of their work that they're making clear the dangers of addiction and that brings us really is the bridge to the second issue, which is the prescribing and how the prescribing goes. And Ms. Capito mentioned your bills and approaches to limiting that. I think we believe right now one of the most important things we can do is put out new prescribing guidelines and then make sure that people are trained in them.

I'm sure you all have the same conversations I have with positions, which say when you talk to physician and you say, "How much time did you spend in training on pain?" And usually, the answer is a very small number of hours if at all and so making sure that we make the advances in terms of that. At the same time, at NIH, we need to continue our research both on the opioid and the treatment of pain side and what work we can do there.

So, prescribing though is an essential key. As reflected, that large number pills, they're going out time and time again and we want to make sure that we're doing everything we can to do that. The NGA just put out a number of proposals that we think align with our three- part strategy and we're going to continue working with them as well.

DURBIN:

Some states are monitoring this and others are not. Shouldn't we have a national standard if we're dealing with national crisis here? Why would we have reporting in some states and -- so we can monitor abuses and in other states not have it?

BURWELL:

So, prescription drug monitoring programs exist in Allstate but one in the union. They are, as you are reflecting, of varying levels of quality. And the other thing that's a problem with them is their ability to talk to each other.

And I did speak with the governors at the recent NGA about getting regional compacts (ph) so we can get some alignment, but at the same time -- and I have two years now running have brought together representatives from each of the governors all 50 states so that we start sharing best practices, so we can start to raise the level of these prescription drug monitoring programs because that's the other thing. If you talk to physicians, they'll say it's hard to use, different technologies, number of clicks, those kinds of things. And so, working to get us the best practice and working to get them to communicate across state lines. And I think in the Northeast, we will get a regional compact.

DURBIN:

Thank you.

BLUNT:

Thank you, Senator Durbin. Senator Moran?

MORAN:

Mr. Chairman, thank you very much. Secretary, thank you for joining us. Thank you for phone call inquiring about the meeting that we were interested in this week about. I'm always interested in a number of issues that face of rural hospitals, community pharmacist. I would do again express my gratitude for the times that CMS, in particular, but to your department has worked with us to try to solve individual issues that create what appears to be insurmountable problems for community attempting to deliver healthcare to patients in the -- in the region, and I just thank you for the past cooperation and ask you where you would continue that and encourage the folks who work with you to understand the distinction and the difficulties that many small town rural providers face.

Let me focus a moment on NIH and the and perhaps -- and I apologize that I was in the Commerce Committee but perhaps you've addressed this, but the mandatory issues that your budget raises are troublesome to me particularly in light of what occurred last year. Congress is stepping up and increasing the support under the leadership of this subcommittee and our full committee and I would encourage you to work with us on budget solutions that are likely to occur once there are -- you continue to propose in some instances, user fees. I chair the subcommittee on Food and Drug

Administration's budget, user fees there, mandatory spending here, are unlikely to be solutions to the budget challenges that you believe your department faces.

And then I want to ask you a specific question related to the state of California. This will -- involves the issue of healthcare provider coverage for abortion. Religious entities, as you would know, have moral objections. They are protected by something called the Weldon Amendment. You were asked a year ago about this issue and indicated that an ongoing investigation was occurring.

The allegation is, as you know, that California requires its providers to provide abortion services that presumably violate the Weldon Amendment that prohibits that requirement. Your answer a year ago was that the investigation was occurring and it would be completed expeditiously. It's now a year later and my question is it the opinion of the department that the order of the California -- of California is a violation of the Weldon Amendment?

BURWELL:

With regard to this issue, I think you known when it was raised with me -- raised both externally but raised by members of Congress, we opened the investigation with the concerns that had been expressed. The investigation is still open. So my ability at this point to have good comment specifically on the question you asked we need to wait for the completion and the finalize investigation for me to comment on the specifics of what the outcome of that investigation is. And so, we are not there yet. And when we are, we will make sure we communicate.

MORAN:

That investigation has been ongoing for how long?

BURWELL:

The investigation has been going -- on going for well over a year.

MORAN:

And you have any opinion as to when that will be concluded?

BURWELL:

My hope is that it will be soon. I wish I could give you timetable, but I don't do that because it is an open investigation.

MORAN:

I will let my questions stand for my concern -- criticism. I'm worried that this is an issue, as you know, that has differences of opinion about the outcome. But in my view, the law is clear. And California is violating the law. It's the administration's responsibility to enforce the law. And I

worry that there may be a plan afoot with which this just continues to the end of your term and in the end of the administration as compared to fulfilling your responsibilities.

BURWELL:

I hear your concerns, Senator.

MORAN:

Thank you, Secretary. Thank you, Mr. Chairman.

BLUNT:

Thank you, Senator Moran. Senator Schatz?

SCHATZ:

Thank you, Mr. Chairman. Secretary Burwell, thank you for being here. Last we spoke, we were talking about Telehealth and we were talking about the sort of two tracks to move on. Since then, we've had some pretty good a legislative collaboration, Senators Wicker, Cochran, Cardin, Thune, Warner and myself, as well as a of a bipartisan group on the House side of introduce the Connect for Health Act, which attempts to amend 1834(m) in such a way that doesn't cost any money to the treasury but also improves outcomes and reduces costs.

My question for you is, we also talked about what you thought you could do within the existing statutory authorities to expand the use of Telehealth and I wonder if you have an update for me.

BURWELL:

We have expanded the number of categories -- some of the categories that we will pay for in that space. And so, I think that's one of the advances that we've made. We're also using Telehealth in situations right now with the tribes. Right now, tribal suicide in the Great Plains is a very serious issue. Our ability to get providers there for those children -- it's child suicide and so we are also working there in new ways to do that.

In addition to the administrative actions though, there are two important statutory actions that are part of this budget that I think is important to highlight because we'd like to get these authorities. One is in this budget you'll see money for HRSA and this gets to the rural issues that we're focused on is that HRSA -- some of our federally-qualified clinics can actually be the sites to do the telemedicine so that we can get that access in rural America and there's money for that in this budget.

The second area is in Medicare Advantage and helping us make some changes statutorily so that we can use Medicare Advantage funding to pay for Telehealth because one of the prohibitions to the growth of Telehealth is the ability for it to be paid for and so the question of whether providers were provided or not. So, we're doing things administratively. There are legislative movements.

Thank you for your leadership and we do have two very specific things in the budget that we think will make a difference.

SCHATZ:

And we'll continue to support you on that as some of those provisions are included in our legislation. So we'll -- whichever vehicle ends up succeeding, I think, we're on the same page. Are there additional administrative actions are on deck or you think you've pushed your authorities to their limits?

BURWELL:

I think we've pushed our authorities, although, you know, yet we continue to look and examine where we can continue to add as we have in terms of adding conditions, but I think we need a little help in terms of the payment issues. The other place that we're working on it in terms of administratively I should mention is in as we're working with accountable care organizations, coming back to Mrs. Capito's question, a number the accountable care organizations are using telemedicine as means by which they can serve their patients better. So, there are ACOs that are doing it.

SCHATZ:

Yes. And can you talk about the Medicare Advantage proposed change. I think it's an important way to make sure that we can -- you know, for Hawaii, it's 40 percent, 50 percent of the market. It makes a big difference and it potentially addresses some of the CBO concerns. So, can you flush that out for us?

BURWELL:

Just the idea that if we can get to the space as you said. Medicare Advantage continues to grow and the coverage of Medicare Advantage across the country, not just in Hawaii, there's deep penetration. So once we can change that payer model in terms of having Medicare Advantage we think we can lead the government as a payer and then others will follow in terms of if we can set a standard and have access to do that.

SCHATZ:

Thank you. Last week, CMS announced a partnership with Hawaii to help navigate how to best leverage Medicaid in the efforts to reduce homelessness. We're encouraged by this partnership and were thankful for working with the state of Hawaii. We have a terrible problem of homelessness. It's unique among states on because of her geographic isolation, because of our -- the cost-of-living, and in particular the cost of housing.

As you know, a lot of these individuals are more likely to have complex medical needs. Can you describe how HHS is supporting efforts to permanently house medically fragile individuals?

BURWELL:

Yes. So, in the addition to the work we're doing directly on homelessness with Hawaii the broader issue that I think gets to issues that each of you probably facing your state in terms of the medically frail and other issues is right now as part of the Center for Medicare and Medicaid innovation and this is just such an important place where you all gave us authorities and money.

Right now, we are actually doing a demonstration to understand when people are coming into the healthcare system. If you can establish whether there are certain other needs that you can connect them to the services that then you can reduce healthcare costs. And what we know is so many people -- the emergency room visits have to do with other complications in people's lives.

And so, what we have seen in some work in the private sector is when you actually asked the question about if the person is homeless, do they need connection sometimes to behavioral health services or other services that we can actually reduce the cost because they become more adherent to their drugs. You know, sometimes they're not taking the drug because they all have food. If you can get them connected to the right place to get the food, they can take the drugs.

And so, there are number of things that we think if we can understand which of these things -- and as you know, as part of what you all gave us in those moneys, we will have to measure and show that there are results financially and that you don't reduce quality of care and hopefully you increase it. So those are the places we're working on.

SCHATZ:

Thank you very much.

BLUNT:

Thank you, Senator Schatz. Senator Cassidy?

CASSIDY:

Hello, Secretary Burwell. How are you?

BURWELL:

Hello.

CASSIDY:

It seems to be a special pleasure when you said it would be the last budget that you would present. And you know, we only have five minutes. So if at any point I interrupt you, it is not to be rude. It is just to expedite.

A week ago, before Energy and Commerce, you were asked regarding the fact that the administration appears to be giving $2 billion to the reinsurance program under the ACA, which CRS says contradicts a plain reading of the law. And knowing that you know that -- knowing that you know of which I speak just for context, I think it's Section 1341. It is at the bottom of page 92, but it's 91 through 93 as where this is.

And in the Energy and Commerce Committee, they pointed out a CRS memo said that they're -- you are giving this $2 billion, quote, "appears to conflict of the statute." You said you not had time to read the CRS report, but they gave it to you. That was a week ago. So any thoughts now after having a chance to review as regard why the administration appears to be conflicting with the statute?

BURWELL:

Senator, we believe that we have the authorities. And as I mentioned in that hearing, we actually published for comment and notice the approach that we were going to take to use those authorities and did not have any of the concerns raised as part of that public process.

CASSIDY:

Now, just to point that out. I can tell you I've seen comments, which is buried within a huge federal register. So sometimes it is not seen until actually implemented, but it says, "Notwithstanding any other provision." I think maybe that's what CRS focused upon. See if I can find it exactly here -- "But nonetheless, it's very explicit. Money remaining unexpended shall be used to make but notwithstanding the preceding and that any contribution shall be deposited into the general fund of the treasury."

So the fact that $2 billion explicitly was said to be put into the general fund, do you have a legal memorandum which would justify your position as opposed about assumed by CRS?

BURWELL:

With regard to the decision that we made, I know that any of our rulemaking's and any of this would have gone through our Office of General Counsel. With regard to the question of a memo, I don't know if it was done in that form. I would say that we believe we have the authorities. And as one looks at this question, it is an issue that I think we're all concerned about, which is downward pressure on healthcare.

CASSIDY:

If I may interrupt again. We have limited time. And that's what you mentioned Energy and Commerce Committee. There is a certain letter of the law and the spirit of the law. And I think you're arguing now that we, by the spirit of the law, would want to decrease, et cetera. But the letter of the law has said, "But notwithstanding any other provision, the money shall be put back into the treasury." So if there -- if you're attorneys have the chance to review the CRS memo, it --

could you share that with us? Because if we're a nation of laws whatever we think about the ACA, if we're nation of laws, they can't be just expediency. It has to be what Congress passed.

I voted against if Congress passed it, and there's a sense right now that it is expediency. It is not the letter of the law not even a kind of a plain reading the laws CRS would put. If I may pause and move to something else, and I don't mean to be rude but we just have such limited time.

Next, understand that there's going to be demonstration project which would decrease on. You mentioned earlier value-based reimbursement for drugs, and currently, as we know, there is the average sales price about 6 percent. I think the fear on the administration is that might be incentivizing the use of more expensive medicines. I'm told there's a demo -- demonstration project that would be rolled out in which that will be modified, if you will. You know far more about this than I, so if you tell me I'm wrong I'll accept that.

What I don't know is, will just be a decrease percentage will be ASP (ph) plus 2 or ASP (ph) plus 4 or will be there -- will there be different model in which value-based purchasing is going to somehow be used to judge what should be the reimbursement or the percent reimbursement on a drug being used?

BURWELL:

With regard to the specific about rolling out proposal, I want to be very careful. These are obviously market moving information. So, I won't (ph) we speak to the specific, but with regard to the general point, I think there is general bipartisan, actually, support for the fact that when you pay someone based on X plus 6 percent butt you actually are going to encourage the person in terms of their own economic well-being...

CASSIDY:

I will accept that.

BURWELL:

... to do that, and so that's what I can speak to the broader issue. With regard to the specific, we will have more to say soon.

CASSIDY:

OK. I got you. OK. Then -- my gosh, rarely do I exhaust my questions before the end of my time, but we're so efficient. Thank you. I yield back.

BLUNT:

Thank you, Senator Cassidy. And there will be time for a second around here. Senator Lankford?

LANKFORD:

I ask unanimous consent for his 30 nanoseconds leftover, so yeah.

(LAUGHTER)

BLUNT:

Denied.

(LAUGHTER)

LANKFORD:

Secretary Burwell, I got a good chance to visit you (ph) again. Thanks for the way you always come through and answer questions. I've -- I've many questions as well. As for a Consumer Assessment of Healthcare Providers System Survey, one of our favorite surveys when you're checking out of the hospital to be able to count score your own hospital which is part of their ranking. You have mentioned multiple times about ongoing (ph) issue.

I have a concern -- my hospitals have a concern that they're being graded and reimbursed based on how they treat pain in the hospital, and that if someone leaves the hospital, which frankly by definition, when you leave a hospital, you're going to experience pain. You don't go there because of the spa treatments. But that if you leave the hospital with pain or feel like the pain is not being taken care well at the hospital, which incentivizes the hospital overprescribed, that they get a bad score and that they are not reimbursed as high.

The simple question is have you looked at the language lately? Have you evaluated the possibility that CMS is incentivizing hospital overprescribed pain meds, and so they get a higher reimbursement because their scores don't go down?

BURWELL:

Yes. We have looked into it. Mr. Alexander raised this issue with me and...

LANKFORD:

Right.

BURWELL:

... we have actually done a look at it. I think what's important to reflect is, we're in the middle of the look at it at an initial look in terms of the analytics, the money is not enough in terms if it's a very, very small percentage. I think...

(CROSSTALK)

LANKFORD:

It is -- I...

(CROSSTALK)

BURWELL:

... I said -- having said that...

(CROSSTALK)

LANKFORD:

... I -- I...

(CROSSTALK)

BURWELL:

... I believe and have gone back to the team that even if it isn't about the economics, it may be about prescribers belief and it may be -- they'd be behaving in ways that aren't economically driven and; therefore, we need to go with this again. I guess we have...

LANKFORD:

I -- I will agree on that...

(CROSSTALK)

BURWELL:

... looked on that.

LANKFORD:

... and I would tell you the hospitals do not tell that the money is not enough for another counting every single penny and so then that is a significant issue and it seems to be an incentive to be able to push doctors. I'm not saying the hospitals are forced them, but it's one of the questions are going back to make sure everyone -- is everyone treating pain because we're to ask when they leave. That creates a very perverse incentive.

Now, we've been talking about your favorite subject, RAC Audits. I -- I can't imagine anything I would want to talk about more fun in RAC Audits. I'd question, one of our hospitals of many just about how RAC Audits are going and what's happening with that. They sent me 49 denials that

they have, 39 of the 49 have so far been overturned. All of these are related to a signature was not there or the date or time was not there.

The question goes back to was it medically necessary? Yes. There shown to be medically necessary but the -- the RAC Audit proposal what we're trying to approach RAC Audits, my understanding was this is going after fraud in medical necessity. It seems to be a tremendous amount. It might just this one group is $650,000 that was about signatures and date and time.

BURWELL:

So, we changed our policy since our last conversation that I hope in ways that will take care of that. So, if an audit -- if one of this is overturned as you just indicated those were, people will not be paid. The other thing is, if it's over 30 days, they will not be paid. And so much of the feedback that we have received from folks like you and your constituents, we've taken into account and now have different policies in place. So...

(CROSSTALK)

LANKFORD:

Is there a possibility to have...

(CROSSTALK)

BURWELL:

... I need that at (ph) hand.

(CROSSTALK)

LANKFORD:

... that financial incentive on the auditors themselves that they're pulling files that have been overturned, that there's a financial penalty on.

BURWELL:

Well, I think they will not receive the economics that is (ph) for them -- in terms of spending time on something you won't receive anything for is an economic incentive, is it enough for that (ph)?

(CROSSTALK)

LANKFORD:

Even if -- even if there's a small penalty on that, just to incentivize them to pay attention to it does help because if they scoop up a bunch and only 20 percent and then get pulled, the incentive is

pulled (ph) the larger amount because then if only 20 percent are going to actually go to all way through in a larger amount of 20 percent still gets it.

There's a whole series of issues that are here dealing with contingency fee structure versus flat fee, reducing the lookback period from not as long, I think it's five years now, if I remember that correctly to lowering that a year or six months, whatever maybe so it's not as perpetual sense of a long lookback on it, trying to deal with good actors when the hospital has or a provider has consistently shown.

They've been good at it, not pulling as large of a group trying to coordinate in the RAC Audits and the ZPCS (ph) to make sure they're not getting both the same time. They are coming out a lot of issues that are out there that I would love to be able to just send you some of these things. I know you're working on them. The issue about the reimbursement they're not paid for and I understand that that was taken care of a long time ago, but there's still more to go. We're still creating a hostile environment.

BURWELL:

So, welcome your suggestions and thoughts, and I think one of the things we all want to do though is make sure that we are eliminating fraud in the Medicare...

(CROSSTALK)

LANKFORD:

I -- I would totally agree that was the -- that was the...

(CROSSTALK)

BURWELL:

... with the...

(CROSSTALK)

LANKFORD:

... that was the intent at the beginning...

BURWELL:

That's correct.

LANKFORD:

... but not getting the date, time and a signature in the right spot on the right sheet is not taking care fraud. That was medically necessary, but we're now holding up large files for it. One last thing, I want to get a chance to get to this, just going back to something Senator Moran had mentioned before on California and Weldon Amendment issues.

Have you gone to the Office of the General Counsel asking legal opinion about California and the Weldon Amendment? Has that been done?

BURWELL:

The Office of our General Counsel will be involved in -- the Office of...

(CROSSTALK)

LANKFORD:

Have -- what the...

BURWELL:

... Civil Rights does the investigation.

LANKFORD:

Correct. Has that been -- is that formal request already been made of them to give a legal opinion to you on it?

BURWELL:

With regard to the question, the General Counsel's office is a part of any of the conversations with OCR in terms of, I'm not sure when you say formal request.

LANKFORD:

Well, just to be able to make sure we're getting legal, but this is a legal question that's out there that seems pretty cut and dry, that if -- that -- yes, it's clear California is violating the law. I can't seem to find any legal (ph) room, and 18 months later, we're still getting -- we're still investigating it. We want to find out after Roses' (ph) investigation after 18 months a clear violation of the...

(CROSSTALK)

BURWELL:

The General Counsel is deeply involved.

LANKFORD:

So, can we get a copy of some of those reports that are coming in, so we can track what's happening. Again...

(CROSSTALK)

BURWELL:

With regard, we're in the middle of an investigation, and when the investigation closes, we will communicate with you...

(CROSSTALK)

LANKFORD:

What you would expect by when?

BURWELL:

... as I said to Senator Moran, at this point, I do not have a timetable, but I do expect us to come to closure.

LANKFORD:

Eighteen months is a long time to look at something...

(CROSSTALK)

BURWELL:

I appreciate that.

LANKFORD:

So, you'd still -- I know it could be another 18 months.

BURWELL:

I don't think it will be another 18 months because I won't be here.

(LAUGHTER)

LANKFORD:

So, it ends -- so it ends at that point or...

BURWELL:

I think probably what -- I do not want to commit to time -- but I think that your question is, is this an issue that will become resolved. I think is your question.

LANKFORD:

Yes.

BURWELL:

I look forward to doing that.

LANKFORD:

In your time. Thank you. I yield back.

BLUNT:

Let's start our second round with Senator Murray.

MURRAY:

Thank you. Again, Madam Secretary, we've talked a lot about opioids and you spoke about the need to increase medication -- medicated us -- medication-assisted treatment to solve the opioid crisis, the importance of naloxone. Could you talk a little bit about how your budget increase increases access to that lifesaving drug?

BURWELL:

With regard to naloxone or what some refer to Narcan, we're using some of the moneys that we have available right now, but portion of the moneys about $1.1 billion that we have asked for would be for those. And what we would want to do is get that money to communities so that first responders can get that - get those treatments and get that out. Some of them -- some of the money would need to be used for training. So, we make sure people know how to use, but we want to get the money out.

In addition, we're complementing those efforts. The FDA just approved recently the most recent nasal Narcan or naloxone, which will mean that others can be able to give it out in terms of people who are trained in terms of injection. So, we're working on that side of it as well.

MURRAY:

And that is part your budget?

BURWELL:

It is --the FDA we've (ph) approved and is moving forward, but we want to make sure the moneys will go towards whatever types of access people want whether it's injection or nasal.

MURRAY:

OK. As I said in my opening statement, I'm concerned about many pressing needs facing the subcommittee but one area I didn't talk about what -- that really worries me is combating antibiotic resistance. As you know, we face the prospect of living in a world where antibiotics are no longer effective and your request includes an additional 40 million at CDC for the second year of initiative to address antibiotic resistant which brings the total to I believe $200 million. I applaud that increase and this is significantly less than you requested last year. It was $264 million, and you're not requesting an increase at NIH or BARDA for addressing antibiotic resistance.

So, I want to ask you where -- where do we stand in our fight against antibiotic resistance? And are NIH and BARDA developing promising new drugs in the pipeline? Is there more to come?

BURWELL:

Yes. In terms of where the money is focused, NIH is focused on making sure that we're developing the antibiotics that are not resistant. At the same time, diagnostics are also a very important part of this in terms of our ability for people to go and be tested and no you don't need an antibiotic because many people demanded it because they think that's what they need and our diagnostics aren't fast and quick enough.

So, that's the part of the research that's doing. BARDA is deeply involved as the drugs and things are coming through and the research gets to the place where we can work with the private sector to move those along that is the part that BARDA is playing. I think with regard to our effort, it is both in research. There's the other part of the effort which has to do with animals and the question of prescribing in animals and through FDA rulemaking.

We're working to get to a place where people only prescribed actually for conditions in animals where there's something wrong with them versus using these kinds of antibodies for growth and other issues and also making sure when they are going to be used in animals, that they are going to be used with a veterinarian in terms of prescribing and making sure that it's being used in an appropriate form.

MURRAY:

This not (ph) blanket given...

BURWELL:

That's right.

MURRAY:

... the reason.

BURWELL:

That's right. And so, working on all of this frankly (ph) the other place I think is very important. I'm glad you raised the issue. I just have the global health security initiative group of countries that President Bush started after a 9/11. This is the group I met in October of 2011 to address and it's our partners like Japan, Mexico, the G7 and Mexico are many of the partners. This is an issue that we talked about specifically. There's a lot of energy on antibiotic resistance, and I think we may even hear conversations about it at this year's United Nations General Assembly.

MURRAY:

In international discussion at this...

BURWELL:

Yes, yes. And so we have our plan, we have a strategy as the United States, but we're also working around the world and in partnership with others. The British have a leadership role, the Germans have a leadership role here to.

MURRAY:

I really appreciate that and talking to doctors at Children's Health Hospitals in Seattle (ph) hearing that kids are born today...

BURWELL:

Resistant.

MURRAY:

... resistant and there's nothing they can do and, therefore, probably (ph) this all -- this an increasing problem. Finally, I want to ask you for a lot of women, the Affordable Care Act expanded coverage of all FDA-approved contraceptives has reduced their out-of-pocket costs and given them access to more effective methods. In fact, we know that women are saved nearly $500 million because of this provision, but unfortunately, we are still hearing from women are experiencing difficulty in getting guaranteed no-cost coverage from their plans.

I understand some insurance carriers are not adhering to the requirements, and I want to ask you if you knew which carriers are requiring cost-sharing or declining coverage or otherwise limiting coverage for contraceptive.

BURWELL:

Since we last spoke, we put out additional guidance to the insurers to make sure they know if there are cases that you're hearing from -- from your constituents, if you can let us know because then it becomes an enforcement matter.

MURRAY:

OK. That -- that's really important, and we will do that and I hope that you'll follow up on that. Great.

BLUNT:

Thank you, Senator Murray. Just as an aside, this is not really a question, but on the mandatory funding issue which I have great confidence to Senator Alexander and Senator Murray and their committee are going to look in a way that doesn't slow us down with discretionary funding, I will say the history of mandatory funding would discourage you on that front.

You know, we had mandatory funding for community health centers. There's been no increase in that account -- discretionary account since that happened. We had mandatory funding for National Health Service Corporation. There's been no discretionary funding at all for that since it went mandatory.

I noticed in your budget this year, you're asking for discretionary funding again from the National Health Service Corporation. It probably doesn't have to be that way, but I will tell you it has been that way whenever there's a mandatory component that steps in, the history of all this has been the whole focus is on maintaining the mandatory component not on what used to be the discretionary funding, and the I would hope that wouldn't happen again.

Senator Murray had a question about the -- about the antibiotics that led me to another thought on pain I meant to make. Is there any advanced being made in trying to find less addictive of pain alternatives and -- and what can we do to encourage that?

BURWELL:

So, I think it can happen in two different ways. Why it can happen in a number of different ways? One is the pharmacy question and making sure that pharmaceutical companies are developing drugs that actually are not addictive, that can be treatments for pain. Another place where we can make probably some advances is actually in how anesthesia is done because if anesthesia is done in a way that a person doesn't have acute pain in this first 24, 48 hours after surgery, and it can depend on the anesthesia that was used to put you under.

I recently had a conversation with the medical providers about that issue -- and the governors actually or the ones who brought up that issue, but I think the other place where we are as a government working on it is actually the Veterans Administration, and the VAS, I'm sure you know has a lot of patience with a lot of pain, and one of the things that Secretary McDonald is focused on their alternative approaches to pain and whether that is approaches like acupuncture and other issues that people can use as alternative approaches to pills for pain and so working

across that whole suite of how we can treat pain at the same time we drew -- reduce the prescribing, I think we need to do both of those steps at once.

BLUNT:

Well, I hope we can find solutions there and in other places on the RAC Audit topic of -- appreciate what you've had to say about that. I think clerical errors are not what we should be headed for here, though we obviously should discourage needless clerical errors but that should not become a reason to hold somebody's money for multiple months at a time.

Last year we did a $20 million increase, that was a little less than you asked for, but this year you've asked for $90 million more, what you think that $90 million get you beyond where we are today?

BURWELL:

I think it gets us a major reduction in the numbers. As I said, we want to work across a three-part strategy. Our success is going to be dependent on the funding of the administrative law judges, as well as some of the statutory changes. I think that both of those together, I think we can reduce this backlog much more quickly. And so the interaction of how much the money will help but at a minimum, we know we're increasing the productivity of our administrative law judges by having administrative changes we're doing.

We're increasing what's going to come in and what we can process. Some of that has to do with settlements and moving things, to do things more quickly. We've asked for the money that we think can put us on a path to get that backlog down, and I think you know right now it's hundreds of thousands.

BLUNT:

And what are you gaining by now looking at clerical errors different than fraud in terms of the backlog?

BURWELL:

I have to go and check on the specific issue of things like signature, and how they go through the system. That's not -- and I apologize. I don't know the answer to that.

BLUNT:

What have you do there I think will be very well received by all of the people who were impacted including the committee because we are constantly hearing from the health care providers we represent that their winning case after case after case but what the money is held for a long time by the time they get it other problems have been created because of the fact that they didn't have the reimbursement that they were of qualified for and that sounds like to me, hopefully we are headed in a much better direction there.

I have a couple of other questions, but Senator Cochran.

COCHRAN:

Mr. Chairman, there's some concern about whether or not the Appropriations Committee's prerogatives are of being supported not by the administration in its totality but a review suggests that they are requesting funding for the legislation under the jurisdiction of the legislative committees instead of through the Appropriations Committee.

Is -- is this accurate or my staff continues?

BURWELL:

Oh, you -- I'm -- I think that -- are they referring to the mandatory request? Is that...

COCHRAN:

Yes.

BURWELL:

... what they're referring to? You know, I --I think this is a question and we have seen it -- Mr. Blunt just gave the examples of where these issues have crossed over, and I think your point Mr. Blunt was not successfully for the long-term. I think -- but we have seen it occur on either side, and I think this comes to the question of where we want to be as a nation with regard to their levels of discretionary spending.

And I think the important issue that we've tried to meet in terms of the standard that we know people care about is making sure things are paid for. In terms of -- as we put the stuff on the mandatory, we didn't just add to the deficit. We put in mechanisms overall that we believe are paying for it.

The question of how we get there with the partial buyback of the sequester and already what we're probably, some might say, tighter levels even before the sequester and how we do it I think it can be done in any number of ways. I think we're trying to do it in a way that's paid for but also speaks with the sequester and the caps that are given.

How it works and whether or not, you know, the caps could go up, we could move to a different place and pay for that again as we have starting with Ryan Murray a number of years ago. I think we're open to the conversation. We've tried to provide monies so that can be covered because I think that's one of the most important things whether it's on the mandatory the discretionary side is how it impacts the deficit.

COCHRAN:

Thank you.

BLUNT:

Senator Alexander.

ALEXANDER:

Thanks Mr. Chairman. I want to go back just for a moment to the question of discretionary mandatory funding again while particularly while these three senators are here, I'm here and you're here. I agree with Senator Blunt. There's a real risk in depending on mandatory funding for the increase we want to see in a bipartisan way for the National Institutes of Health.

Now, some will want to see more and some will think we can afford less but there is unusual consensus right now that we want to take advantage of this period of time -- this exciting period of time in science that has the opportunity to help so many people. And for my part I'm not interested in saying mandatory funding replaced discretionary fund.

I want me -- I'd like to see us have a goal. We did this and the award the bill (ph) with harbor, you know, to deepen our harbors, we saw that as a national imperative and the Congress said this is the funding goal that we want over the next several years and we've met it for the last two and were making pretty good progress on deepening our harbors before the fem (ph) walk in our lives.

Now, this is different and I would think a more urgent issue so I'd like to not think about mandatory funding as a replacement for what we should be doing with discretionary funding. And I think we should build on the 5% increase of this past year discretionary funding and continue to move upward and forward if we possibly can and if I, you know, well that's hard to do but that's our job to set priorities.

So, I think about mandatory funding and I'm being a little repetitive here is in addition to that and when I think about that way I want to try to make sure that make it -- I want to make it hard for people to think of the mandatory funding as a substitute. So one way of -- and we several officers talked about this is to have this innovation fund.

To take several areas were Dr. Collins, you, the President have said these are urgent areas and they have a -- they have a -- they have a timeline and they have a beginning and an end. So, for example we might add to the precision medicine launch X billion for X years.

And when that was over it began. You couldn't say that's going to replace discretionary funding or the same with 650 more young investigators for a period of time. The Congress could replace that but wouldn't have to, the big bow think award.

Dr. Collins has talked about that giving each of the institutes an amount of money for the biggest idea in their field to see what that turns up the cancer moonshot we've yet to hear exactly what that is but we look forward to that. Or -- let's take the brain initiative and Senator Cassidy even suggested this the other day I thought it was interesting.

He said that perhaps one way to think about it is a surge of funding. The mandatory funding will be a surge on top of the discretionary funding. So, we have the discretionary going up every year that would be our goal.

But we get there -- we can move there more rapidly if we had a mandatory surge going on for the first, four or five years then they come together would be closer. I thought that was pretty interesting. So, that's the way I'm thinking about. And I just wanted to say those things while we're all here.

BURWELL:

Building on that thought and that approach as you think about medication as a treatment and getting that initial capacity, you know, the idea of that what you need to do because behavioral health and many of these issues are taken cared of at the state and local and that what we do is we actually jumpstart the state and local communities' ability to get to a place where they have the capacity and then they take it on. And so to build on your idea, I think there are approaches that we can think through that that might work in terms of your approach to thinking of it as additive but not replacement.

ALEXANDER:

If I may interrupt, if you did it that way, let's say we had a five-year surge to help launch precision medicine we would have to spend the same amount every year. In fact, that's maybe a waste of money, we might spend some this year some next year the most the third year less fourth year back down the fifth year, that might be the most effective use of money that can be done with mandatory -- that can be done with mandatory part.

So, I and then I just want to reiterate the obvious I mean there's a lot in the legislation that Sen. Murray and I are working on in support of precision medicine in addition to the money I mean the electronic healthcare records if you've given a lot of attention to getting -- giving you the -- and I say the authority to share its researchers to share their data more flexibility.

So, you could have more arrangements like the Google Vanderbilt arrangement that you announced the other day, strengthen privacy protections that, plus the electronic medical records are absolutely essential for the precision medicine initiative as well as the money and I just want to reiterate none of that is likely to happen unless it's part of this bill we're doing.

So, we have to get a result -- that's we have to come to some consensus and I hope we do by about mid-April.

BLUNT:

Well, Secretary Burwell, we were on the -- on the research component and in fact on many of the things we're talking about I think there is a commonality of goals here -- the shared goals that

hopefully we can figure out to take advantage of and, you know, our increase in NIH research was actually 6.6% that's 5% plus inflation, that's a goal.

Like Senator Durbin said if we just have to add that as our goal from now on that would do a lot for families, that would do a lot for taxpayers in a way statistic that gets everybody's attention when a user or projection is that on Alzheimer's loan were spending quarter of a billion dollars, a quarter of a trillion dollars annually right now we'll be spending a 1.2 trillion of today's dollars by 2050 which is more than twice the defence budget.

And when you, you know most people including me, when you say $1.2 trillion that doesn't trigger a whole lot in my mind that's more scary than some lower number than that when you say twice the defence budget obviously whatever we learned in this -- in this what would be a relatively small investment in research is important, but if you're going to have a pattern the second year of the pattern is really important.

So, we did $2 billion added two billion to the 30 billion last year, this would be a terrible year to wind up cutting that by 800 million. This would be a great year to add another 5% plus inflation. In addition to whatever else we can do for short-term ways to move us forward there.

My last question is going to be on just mental health. I do appreciate your stepping forward looking at excellence in mental health. And again while I've got -- I'll tell just exactly what Senator Alexander did while I've got Senator Alexander and Senator Murray here, I would say when we were able to pass the demonstration projects on excellence in mental health which have been very well received by the mental health community, the goal that Senator Stabenow and I have -- when we introduced that legislation was that the initial problem to be solved is having somewhere to go.

Having providers is really important, various different ways to handle privacy issues that might relate to your support group is important but if you don't have anything -- anywhere to go none of those things really matter. And I know you're looking at a way we can move from 8 to 14.

We're looking at some talking to CBO about some numbers that might let us move forward because I think and this is a question to you I think what is generally believed to be the case and what initial studies have indicated is it really now is the right thing to do but really doesn't cost anything in total healthcare dollars to treat behavioral health like all other health because it's so much easier to deal with every other problem that someone has that has a behavioral health problem, why don't you (ph) comment on that?

BURWELL:

Yes, and I think it gets to that part of the conversation we had with senator from Hawaii in terms of the importance of how these issues interact with our overall healthcare cost and whether it's behavioral health issues are also the issues of people's homelessness other kinds of things that inhibit people from getting to the help they do.

I think you know we have put the money in to build on the project that you and Senator Stabenow and Miss Matsui on the health side have been very engaged in. I think you know we've worked

with you to implement it faster in the statutory deadlines in terms of getting everything out. Because we want to shift very quickly to what you said where there is equity in terms of behavioral health issues and there are places for people to go to do it.

We think we can do that in ways I think as you indicated that can move us to place where we have a delivery system reform to at the way you've done it in terms of quality measures, access for people and getting to a place where you get better quality at a more affordable price.

BLUNT:

Right. Well, I think the way we allowed the -- well, that we've required really the law enforcement community in emergency rooms to become the go to a place for behavioral health is outrageous -- just outrageous. Also on the opioid problem and Senate Shaheen will come in right after and this is an issue that she has been very engaged and Telehealth, I have an amendment that I believe will be accepted on that bill that would allow Telehealth also be part of the mix of things coming together for dealing with opioids, Senator Shaheen?

SHAHEEN:

Well, thank you Mr. Chairman and thank you very much Secretary Burwell for being here today and just to pick up on the comments about behavioral health as you both know and the committee knows I'm sure that's a critical piece of addressing the substance abuse problem that we have in the country.

We are not talking about just reading overdoses and subs -- you know, heroin and opioid abuse but often there is a mental health issue that accompanies that and so we've got to start looking at this is an integrated system that treats the whole person.

And I very much appreciate what you have put in and the administration has put in to address that heroin and opioid, I call it a pandemic because that's what it really is we're losing 47,000 people a year in New Hampshire, we're losing more than a personal day due to drug overdoses.

And the Chairman talked about the emergency supplemental funding that we tried to pass yesterday as we were trying to get the comprehensive addiction and recovery act through I was disappointed that that did not pass because as I've travel around what I hear from whether it's that treatment providers or whether it's families who have lost someone or trying to get someone into treatment or law enforcement professionals, the issue is the same.

And that is that they are looking for funding because they don't have the resources they need and just to give one example I don't know if you've talked about this but we've chronically underfunded the accounts within Health and Human Services that allows to provide treatment and prevention.

And in fiscal year 7 -- 2017, it would take $483 million just to bring SAMHSA -- Prevention and Treatment Block Grants back to levels in 2006. So, can you -- with that as a little background -- can you talk about how -- how the -- your budget will address the drug abuse epidemic and how

you're coordinating with other agencies within the federal government to address this huge problem that so much of the country is facing?

BURWELL:

Thank you for your leadership especially in the area of the funding issue which I think, you know, we think is critical and have discussed because it is about it's, you know, what you just said Mr. Blunt in terms of if people can't get access to the care and if that's not available and that's the issue.

And as I've said, you know, I've talked to the sheriffs who say I don't want to be a healthcare provider and I don't want to be a social worker but I see this person again and again and again. And, you know, I have young men who have -- are trained to do law enforcement but not trained to help a person get off of their addiction.

Or, you know, we apply the Narcan but then I'm going to see them again. And so having that access and that's what the vast bulk of that money goes towards in terms of the medication assisted treatment that's why because we need to build the capacity. And it is related to our behavioral health issues that we don't have the capacity that we need across the country.

And that's why I'm happy and open to thinking about it as one time shot to get the capacity but as you reflected the budgets of SAMHSA and other parts of our organization that deal with these issues have not grown with inflation over the past years.

And so that's why I think it's a critical moment for the increases that we need to see and I think more than anything it's about the problem and the magnitude of the problem because I don't know that one should argue that you should just grow it if I don't believe that having come from OMD, I, you know, require, you know, the departments when I was there.

And so I don't believe that it's just about growth year-over- year. Actually, it's about need and so that's where I would focus the issue of the money. With regard to our coordination with others, we obviously coordinate very closely with the Office of the National Drug Coordinator Mr. Botticelli at the White House but also with our partners as I mentioned VA is working on the pain issue.

So, I have met with Secretary McDonald so that they can make progress in that space, spent time with the Attorney General. One of the things that PDMPs which we discussed earlier the Prescription Drug Monitoring Programs that I think it was Senator Durbin who raised, those are actually much of that work is done out of justice.

The other thing is drug take backs are done out of justice. The other issues around heroin, we've talked about them in conjunction with the opioids and the transition of people make but there's also the heroin coming into our country and that's more Justice Department issue.

So, we're working in coordination with those of the main pieces but also as you know Secretary Vilsack has become engaged on the rural part of this and he is helping us in that space as well as a voice - the convener and getting to one of the other attenuated issues which is economic. You

know, USDA is so focused on rural economic development and so they are a part of that solution as well.

SHAHEEN:

Thank you Mr. Chairman, my time is up but can I ask one more question?

Okay. Thank you.

I know that you're also focused on the Zika Virus and what we need to do to get in front and as you pointed out it's very scary to think of what the potential impact of that could be. We just had a woman in New Hampshire who is diagnosed as having the Zika Virus fortunately she was not pregnant but she had gotten it through sexual transmission with her partner who had been in the Caribbean.

But can you speak to the role of family planning in -- and the accounts that are included in the budget and the role that they play in the life of women and families as we look at something like a potential Zika Outbreak?

BURWELL:

I think one of the things we're very focused on is making sure that everyone have the information that they need to make the choices and decisions that they need to make and then that they have access to the tools that they need in what was regard to family planning and contraception.

Our budget and the proposal, the supplement proposes no changes to our approaches in terms of making sure that there's access. We talked a little bit about that access issue in terms of the Affordable Care Act and the idea that you can do this without copayments in terms of not being charged.

And so we are very focused on making sure that people have the right information to make the right choices for them especially in the area of contraception and protection. And I think you know we have recommended that there'd be no unprotected sex for pregnant women who have partners who have travelled to the region and that's the guidance that we have offered from CDC during the entire time of the pregnancy.

And so we -- as we learn more, we'll continue to put our updated guidance as soon as we get the research back. I'm hopeful that in the next -- that we'll see more research in terms of women in their pregnancies and understanding if there's a more acute impact in that first trimester like we have seen with measles and rubella.

If it -- does it follow that pattern or not we don't know yet but as we get more information so that people can make the choices across the board with regard to prevention as well as use of contraception during pregnancy.

SHAHEEN:

Thank you.

Thank you Mr. Chairman.

Madam Secretary, thank you but I just want to clarify one thing and conclude. So, your recommendation CDC is that women -- even if a man travels in October and his wife is pregnant for nine months' unprotected sex in coming back from travelling to foreign country?

BURWELL:

We recommended they are careful because right now we cannot determine how long Zika lives in semen. We know that Zika lives in blood for -- a research today has showed that Zika lives in a person's blood system in terms of that.

We think it's about a week after you have had finished the disease. But remember for 80% of the people you don't know if you had it or not, because you don't -- you're not symptomatic. With regard to semen, we don't know yet.

SHAHEEN:

So, it could be much longer than...

BURWELL:

We don't know.

SHAHEEN:

All right. With that, thank you very much. I do have additional question, I'll submit for the record but thank you very much Mr. Chairman.

BLUNT:

Well, the questions -- the record will be open for questions -- one question I'll ask for the record but I want to be sure that it was heard today is I've had lots of concern about round three of the competitive bidding for durable medical equipment, some concern that we're rushing into those changes to quickly, and that they'll have a negative impact on seniors, pardon me...

(COUGHING)

BLUNT:

... on seniors living in rural Missouri and I'll have two or three questions on that topic as others will have on other topics so the record will stay open for one week for additional questions and the

subcommittee will stand in recess until 10 AM on Thursday, March 10th. Thank you for being here Secretary.

BURWELL:

Thank you.