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NOMINATION OF SEEMA VERMA

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON THE

NOMINATION OF

SEEMA VERMA, TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

FEBRUARY 16, 2017



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NOMINATION OF SEEMA VERMA, TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

THURSDAY, FEBRUARY 16, 2017

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

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Roberts, Enzi, Cornyn, Thune, Burr, Isakson, Portman, Toomey, Heller, Scott, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Menendez, Cardin, Brown, Bennet, Casey, Warner, and McCaskill.

Also present: Republican Staff: Chris Campbell, Staff Director; Kimberly Brandt, Chief Health-care Investigative Counsel; Brett Baker, Health Policy Advisor; and Erin Dempsey, Health-care Policy Advisor. Democratic Staff: Joshua Sheinkman, Staff Director; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Advisor; David Berick, Chief Investigator; Beth Vrabel, Senior Health Counsel; Ann Dwyer, Health-care Counsel; Matt Kazan, Health Policy Advisor; and Ian Nicholson, Investigator.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. I would like to welcome everyone to this morning's hearing. Today we are going to consider the nomination of Seema Verma to serve as Administrator of the Centers for Medicare and Medicaid Services.

Welcome, Ms. Verma. We are so happy to have you here and your family as well. I appreciate your willingness to lead this key agency at this critical time. And I see that your family has joined you here today to lend support, so I extend a warm welcome to them as well.

CMS is the world's largest health insurer, covering over one-third of the U.S. population through Medicare and Medicaid alone. It has a budget of over $1 trillion, and it processes over 1.2 billion claims a year for services provided to some of our Nation's most vulnerable citizens.

Ms. Verma, having dealt with CMS extensively in your capacity as a consultant to numerous State Medicaid programs, you know full well the challenges the agency deals with on a daily basis. And

I suspect you also know that the job you have been nominated for is a thankless one, fraught with numerous challenges.

The good news is that there are opportunities in those challenges, and I believe you are the right person for the job and that you will make the most of those opportunities to improve our health-care system.

The failings of Obamacare are urgent and must be addressed in short order. Over the past 6 years, we have watched as the system created under Obamacare has led to increased costs, higher taxes, fewer choices, reduced competition, and more strains on our economy. Under Obamacare, health insurance premiums are up by an average of 25 percent this year alone.

Under Obamacare, Americans, including millions of middle-class Americans, have been hit with a trillion dollars in new taxes. And under Obamacare, major insurers are no longer offering coverage on exchanges. And earlier this week, we learned that another major carrier will exit the market in 2018.

As Congress works to change course with regard to our ailing health-care system, CMS will play a major role in determining our success. I applaud the step the agency took yesterday under the leadership of HHS Secretary Price with its proposed rule to help stabilize the individual insurance markets. But there is much more work to be done, and I am confident that if you are confirmed, and I expect you to be, you will be a valuable voice in driving change.

Now, I would like to talk specifically about Medicaid for a moment. The Medicaid program was destined to be a safety net for the most vulnerable Americans. As such, I understand and value the moral and social responsibilities the Federal Government has in ensuring health-care coverage for our most needy citizens.

I am committed to working with the States and other stakeholders, as I think everyone on this committee is, and, of course, the American public, to improve the quality and ensure the longevity of the Medicaid program. But we must also acknowledge that the Medicaid program is three times larger, both in terms of enrollment and expenditures, than it was just 20 years ago.

Additionally, the Medicaid expansion under Obamacare exacerbated pressures on the program at a time when many States were already facing difficult choices about which benefits and populations to serve. And as a result, we have a responsibility to consider alternative funding arrangements that could help to preserve this important program. We also need to consider various reform proposals that can improve the way Medicaid operates.

Ms. Verma, we will need your assistance in both of these efforts. And your experience in this particular area should serve you well.

On the subject of Ms. Verma's experience, I want to note for the committee that she has been credited as the creative force behind the Healthy Indiana Plan, the State's Medicaid alternative. This program provides access and quality health care to its enrollees while ensuring that they are engaged in their care decisions.

The program continues to evolve while hitting key metrics, and, overall, enrollees are very satisfied with their experience, as I understand it. And while we may hear criticisms of this program from the other side of the dais here today, we should note that HHS and

CMS leaders under the Obama administration repeatedly approved the waiver necessary to make this program a reality.

Ms. Verma has assisted a number of other State Medicaid programs as well. Her efforts all have the same focus: getting needed, high-quality health care to patients and to engage patients in a fiscally responsible way. This is exactly the mind-set we need in a CMS Administrator.

Now, Ms. Verma, as if the challenges associated with Medicaid are not enough to keep you busy as CMS Administrator, you will also be tasked with helping to ensure the longevity and solvency of the Medicare trust fund, which is projected to go bankrupt in 2028. That has already come down from 2032, I believe.

All told, between now and 2030, 76 million baby boomers will become eligible for Medicare. Even factoring in deaths over that period, the program will grow from approximately 47 million beneficiaries today to roughly 80 million in 2030.

Maintaining the solvency of the Medicare program while continuing to provide care to an ever-expanding beneficiary base is going to require creative solutions. It will not be easy, but we cannot put it off forever. And the longer we wait, the worse it will get.

Now that I have had a chance to discuss the challenges facing CMS and some of Ms. Verma's qualifications, I would like to speak more generally about recent events.

We have gone through a pretty rough patch recently on this committee, particularly as we have dealt with President Trump's nominations. I do not want to rehash the details of the past few weeks, but I will say that I hope that recent developments do not become the new normal for our committee.

As I said before, I am going to do all I can to restore and maintain the customs and traditions of this committee, which has always operated with assumptions of bipartisanship, comity, and good faith.

With regard to considering nominations, that means a robust and fair vetting process, a rigorous discussion among committee members, and, of course, a vote in an executive session. On that note, maybe the icy treatment of nominees is starting to thaw today; at least I hope it is.

One tradition that has been absent before this session has been the introduction on many occasions of nominees by Senators of both parties from the nominees' home State, especially in cases when the nominee and the home State Senator have a relationship.

I am pleased to say that the senior Senator from Indiana is reaffirming that tradition by appearing here today, and so is our other Senator from Indiana. I thank these Senators for taking time to appear today and to introduce their constituent. I will give them a chance to do so in just a few minutes.

With that, I look forward to Ms. Verma sharing her vision and views here today. I also look forward to what I hope will be a full and fair committee process that allows us to process this nomination and report it to the full Senate in short order.

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

The CHAIRMAN. I will now at this time recognize my co-chair on this committee, Senator Wyden, for his opening statement.

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman.

And welcome to you, Ms. Verma, and to our colleagues from Indiana.

I just thought it was worth noting that with the Hoosier basketball tradition, Ms. Verma, it looks like you have brought close to two squads of basketball players. [Laughter.]

And we welcome you and your family today.

It is obvious that the health-care post that we are going to discuss today is not exactly dinner table conversation in much of America. But the fact is, it is one of the most consequential positions in government.

The agency is responsible for the health care of over 100 million Americans who count on Medicare and Medicaid. It plays a key role in implementing the Affordable Care Act. And that is why CMS needs experienced and qualified people for the job, people who know the ins and outs of the whole system: Medicare, Medicaid, and private insurance.

The agency needs a strong and experienced authority. And this is particularly true now when it does appear that some of my colleagues on Capitol Hill, many in the administration, are looking to make radical changes to American health care. In my view, many of these proposals would take the country back to the days when health care was mostly for the healthy and the wealthy.

So we are going to start with the promise of Medicare, which has always been a promise of guaranteed benefits. That makes up more than half of the agency's spending, about $2-billion-plus a day. With more seniors entering the program each year, there is an awful lot to do to protect and, in my view, update the Medicare guarantee for this century. That means addressing the high cost of prescription drugs. It means making the program work better for those with chronic illnesses, like heart disease and cancer, which is the majority of the Medicare spending today. It is going to take bipartisan support.

Privatizing Medicare is the wrong direction in my view. It is important to hear today, Ms. Verma, how your views differ from some of the policymakers who are advocating those kinds of approaches, who would literally be interested in turning the program into a voucher system.

Additionally, if confirmed, you are going to play a key role in implementing the Medicare physician payment reforms. It is essential that they be implemented as intended by the Congress, because we want to start moving health care from paying for volume to paying for value.

Also, the agency implements rules of the road in the private insurance market. And today, many of those rules amount to bedrock values for health insurance in the country. It means not discriminating against those with a preexisting condition no matter what. It means setting the bar for what type of medical care insurance companies have to cover. And it means letting young people stay on their parent's policy until 26.

Unfortunately, just yesterday the agency released a proposed rule that, in my view, goes in the opposite direction. From where

I sit, the message from yesterday's rule is, insurance companies are back in charge and patients are going to take a back seat.

The open enrollment period, for example, was cut in half from 3 months to 6 weeks. If somebody dropped coverage during the year for any reason, insurance companies could collect back premiums before an individual can get health insurance again. And insurance companies would have free reign to offer less generous coverage at the same or higher cost.

This, again, sounds to me like it is going back to yester-year when the health-care system really did work for the healthy and wealthy.

Now the administration has been saying, of course, that the best is yet to come. The evidence, it seems to me, suggests otherwise. The President could have taken steps to create more stability on a bipartisan basis, but instead issued an executive order on the day he was sworn in that is obviously now creating market uncertainty and anxiety. And you do not have to look much further than Humana's decision here in the last day or so.

So we want to hear from you, Ms. Verma, this morning about how you are going to implement this program that millions of Americans count on and how you are going to do it even though we have Republicans here who want to unravel the law.

In short, I want to see us get beyond what has come to be known as "repeal and run." And repeal and run goes beyond disrupting the individual market. It would also end the Medicaid expansion that brought millions of low-income, vulnerable Americans into the health-care system. And this is an area, obviously, where you have extensive experience.

I want to discuss some of the tradeoffs associated with those efforts. And I am particularly concerned about the possibility, as I have been informed, that somebody making barely $12,000 a year would get locked out of health coverage for no less than 6 months because they could not pay for health care due to an upcoming rent check, for example, or an emergency car repair.

There has been an independent evaluation indicating that 2,500 people were bumped from coverage due to situations like this.

I have also seen in that same report that more than 20,000 persons were pushed into a more expensive, less comprehensive Medicaid plan because they could not navigate this system that you all put in place.

Now, I want to wrap up with just two last points, Mr. Chairman.

One, with respect to taking these ideas on a nationwide tour, I am not there yet. And I say that respectfully. We will hear more about the program.

And here is the point with respect to the States—and we touched on it in the office. We authored section 1332 of the Affordable Care Act, saying that States can do better. If States have an idea—better coverage, lower costs—God bless them, we are all for it, but we cannot use 1332 or any other provision for the States to do worse.

One last issue that I want to touch on deals with Ms. Verma's work.

As I understand it, you had a consulting firm. You all were awarded more than $8.3 million in contracts directly by the State

of Indiana to advise the State. And that was while you all were managing the programs. In effect, you were the architect.

At the same time, as has been told to me, you contracted with at least five other companies that provided hundreds of millions of dollars of services and products to these programs: HP Enterprises, Milliman, Maximus, Health Management Associates, Roche Diagnostics.

And with at least two of these firms, HP and HMA, the terms of the State contracts appear to have had you, in effect, overseeing work that the firms performed.

Now, George W. Bush had an ethics lawyer, a fellow named Richard Painter. He was not exactly a liberal guy, and he said yesterday that this arrangement, and I will quote him, "clearly should not happen and is definitely improper." He, in effect, said that you were on both sides of the deal helping to manage State health programs while being paid by vendors to the same programs.

He said that was a conflict of interest. I want to hear you respond to his assertions.

So we are going to want to know more about your work for companies that did business with the State. And one of the questions will be, if you are the CMS Administrator, if you are confirmed, would you recuse yourself from decisions that affect the companies that were your clients?

We will look forward to your testimony with the two Indiana Senators. You are running with the right crowd.

And thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator.

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

The CHAIRMAN. I am pleased to hand over my normal witness introduction duties today to a pair of our distinguished colleagues. That both Senators from the Hoosier State will introduce Ms. Verma is a statement and a testament to her work and to her as a person.

I ask that the senior Senator from Indiana, Mr. Donnelly, start the introduction, and then turn it over to Senator Young.

Senator Donnelly, you go ahead and proceed.

STATEMENT OF HON. JOE DONNELLY,
A U.S. SENATOR FROM INDIANA

Senator DONNELLY. Thank you, Mr. Chairman.

Chairman Hatch, Ranking Member Wyden, members of the committee, thank you for inviting me here today. It is a pleasure to be here with my friend and colleague Senator Todd Young to recognize this important accomplishment of a fellow Hoosier.

As you know, any time the President nominates an individual for a leadership position in our government, it is an honor and a reflection of the tremendous trust and respect he has in that person.

For this reason, I am pleased to be here today to help recognize Ms. Seema Verma for her nomination to be the next Administrator for the Centers for Medicare and Medicaid Services, CMS, and introduce her to this committee for your consideration.

I have always held a personal belief that we accomplish more when we work together. In Indiana, we call that Hoosier common

sense. And working collaboratively to help Hoosiers get access to quality health care is something Ms. Verma and I have had the opportunity to do together.

As many of you are already aware, Ms. Verma has played a central role in crafting Medicaid policy in many States, including our own.

In Indiana, she worked with Governor Daniels and then Governor Pence, as well as other State and Federal partners, to take advantage of opportunities made possible by the Affordable Care Act to expand Medicaid through the Healthy Indiana Plan, also known as HIP.

Today, HIP 2.0 has helped to lower our State's uninsured rate, improve health-care outcomes, and has played a critical role in combating the opioid abuse and heroin use epidemics.

Hundreds of thousands of Hoosiers currently have health insurance through HIP 2.0. And the program is an example of what is possible when we work together.

As I have shared with Ms. Verma and I will share with you, I am deeply concerned about the future of health care in our country as well as the rhetoric surrounding the current debate. I firmly believe that maintaining access to critical programs like Medicaid and Medicare and building upon the progress of the ACA is fundamental to both the physical and financial well-being of thousands of Americans across our country.

It is my sincere hope that this administration, working with this committee and others, will approach Medicare and Medicaid with the thoughtful and pragmatic consideration these critical programs deserve.

I have watched Ms. Verma take this common-sense Hoosier approach, and I hope she uses this opportunity today to share with you her vision for how she can work together with all of the members of this committee and Congress as a whole to expand access to quality health care and protect and build on the progress we have made over the last several years.

With that, Chairman Hatch, Ranking Member Wyden, members of the committee, thank you for allowing me to introduce Ms. Verma.

To Ms. Verma and her family, congratulations on this tremendous honor. I look forward to Ms. Verma's testimony.

And I thank the committee for your hard work and your consideration of Ms. Verma for this very important position.

The CHAIRMAN. Well, thank you very much.

Senator Young, you now can proceed.

STATEMENT OF HON. TODD YOUNG,
A U.S. SENATOR FROM INDIANA

Senator YOUNG. Well, thank you, Chairman Hatch, Ranking Member Wyden, and members of the committee. It truly is an honor to be with you to introduce a fellow Hoosier, Seema Verma, to be Administrator of the Centers for Medicare and Medicaid Services.

You know, President Trump simply could not have made a better choice in selecting Seema to lead what is arguably the most impor-

tant office within HHS, an office that covers the health-care needs of over 100 million Americans, with a budget of almost $1 trillion.

In her 20-year career as an innovator in the health-care sector, she has worked extensively with a variety of stakeholders from both sides of the aisle to deliver better access to health care.

As president, CEO, and founder of SVC, she helped several States to redesign their archaic Medicaid systems, including in my home State of Indiana. Seema revolutionized the Medicaid program as architect of the Healthy Indiana Plan, which we know as HIP. It is the Nation's first consumer-directed Medicaid program. She transformed a complex, rigid Medicaid system into one where Hoosiers are back in control of their health-care needs.

Since 2007, HIP has achieved impressive results. Hoosiers are more likely to seek preventative care, take their prescription medications, and seek primary care services at their physician's office, not the emergency room.

Seema's innovative idea is working and is now an important proof of the concept that Medicaid can be more efficient than a one-size-fits-all approach. And she accomplished this with the support and buy-in from people, again, on both sides of the aisle and at all levels of the process.

By putting the mission above politics, she demonstrated a willingness to work with anyone—anyone—who was willing to do the same. She worked with Democrats in the Indiana Statehouse. She worked with the Obama administration to find common ground on how to best provide quality health care to hundreds of thousands of low-income Hoosiers. And it worked.

As CMS Administrator, Seema will have the ability to use her extensive experience to help other States achieve what we have in Indiana: better health outcomes for our most vulnerable. I look forward to working with her.

I thank you, sir.

The CHAIRMAN. Well, thanks to both of you, Senators. It is a real honor for the committee to have both of you come. And I know Ms. Verma really appreciates it.

Senator YOUNG. Thank you.

The CHAIRMAN. We know you are busy, so we will let you go.

Ms. Verma, we are now going to turn to you for your comments and your feelings on this nomination, and then we will turn to questions from the Senators up here.

STATEMENT OF SEEMA VERMA, NOMINATED TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. VERMA. Good morning, Chairman Hatch and Ranking Member Wyden. I appreciate and am grateful for your consideration of my nomination by President Trump to be the Administrator for the Centers for Medicare and Medicaid Services. And I thank you for the time that many of you have spent with me in advance of the hearing. And I appreciate hearing about your priorities.

Before I begin my statement, I would like to take a moment to introduce my family. With me today are my parents, Mr. and Mrs. Verma; my husband Sanjay; my two kids, Maya and Shaan; and

the rest of my family and friends who are here with me. I really appreciate it; thank you.

I have often been asked by my family and my friends, as well as many members of this committee, why I would be interested in this job. I was honored and humbled and accepted President Trump's call to service because I understand what is at stake.

I have never stood on the sidelines of our Nation's health-care debate, merely pointing out what is wrong with our health-care system. More than 20 years ago when I graduated from college, I started my career working on national policy on behalf of people with HIV and AIDS, as well as for low-income mothers to improve birth outcomes.

I fought for coverage, greater health-care access, and for improving the quality of care, and I have continued to fight for these issues for the past 20 years.

But I am deeply concerned about the state of our health-care system, as there is frustration all around. Many Americans are not getting the care that they need, and we have a long way to go in improving the health status of Americans.

Doctors are increasingly frustrated by the number of costly and time-consuming burdens. Health care continues to grow more and more expensive, and the American people are tired of partisan politics. They just want their health-care system to be fixed. And I know this, not simply because I have worked in health care, but because of how intimately it has affected my own personal life.

My mother is a breast cancer survivor, due to early diagnosis and treatment. And a few years back, my neighbor Aidan was diagnosed with a stage IV neuroblastoma. He was only 4 years old. A large tumor had been growing for some time, maybe since he was born, and it was wrapped all around his kidney. Aiden went through excruciating, painful chemotherapy, radiation, stem cell treatment, and surgeries, all experimental.

This May, Aidan will celebrate his 12th birthday. And both my mom and Aidan are testaments to the grace of God and the ingenuity of the American health-care system. This is why people travel from all across the world to get care in the United States.

I want to be part of the solution, making sure that the health-care system works for all Americans so that families like my own and Aidan's have the care that they need. I want to be able to look my children in the eye and tell them that I did my part to serve my country and to be a voice for people who often do not have one.

This is a formidable challenge, but I am no stranger to achieving success under difficult circumstances.

My father left his entire family to immigrate to the United States during the 1960s and pursued four degrees while working to earn money. On my mother's side, my grandmother was married at the age of 17 with no more than a fifth-grade education, but my mother went on to be the first woman in her family to finish a master's degree.

My parents made a lot of sacrifices along the way to provide me with the opportunities that they did not have and have taught me the value of hard work and determination.

I am extremely humbled as a first-generation American to be sitting before this committee after being nominated by the President

of the United States. It is a testament to the fact that the American dream is very much alive for those willing to work for it. And it is my dream and my passion to work on the front lines of health care to improve our system.

Throughout my career, I have brought people together from all sides of the political spectrum to forge solutions that worked for everyone. One of my proudest moments in my career was watching the Indiana legislature pass the Healthy Indiana Plan, which is a program for the uninsured, with a bipartisan vote.

CMS is a $1-trillion agency and covers over 100 million people, many of whom are amongst our Nation's most vulnerable citizens. Providing high-quality, accessible health care for these Americans is not just a luxury, it is a necessity and often a matter of life and death.

Should I be confirmed, I will work with the CMS team to ensure that the programs are focused on achieving positive health outcomes and improving the health of the people whom we serve. To achieve this goal, I will work towards policies that foster patient-centered approaches that increase competition, quality, and access, while driving down costs.

Patients and their doctors should be making decisions about their health care, not the Federal Government. We must find creative ways to empower people to take ownership for their health. We should support doctors in providing high-quality care to their patients and ensuring that CMS's rules and regulations do not drive doctors and providers from serving the people, our beneficiaries.

If confirmed, I will work towards modernizing CMS's programs to address the changing needs of the people they serve, leveraging innovation and technology to drive better care. I will ensure that efforts around preventing fraud and abuse are a priority, because we cannot afford to waste a single taxpayer dollar. I will work towards ushering in a new era of State flexibility and leadership to drive better outcomes.

If I have the honor of being confirmed, I will carry this vision along with my strong belief in open communication, collaboration, and bipartisanship. I will work with you, be responsive to your inquiries and concerns, and value your counsel.

I thank you for the consideration of my nomination.

The CHAIRMAN. Well, thank you so much. We really appreciate your willingness to serve. And I look forward to getting you through this process.

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

The CHAIRMAN. I have some obligatory questions to ask you. First, is there anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Ms. VERMA. Sir, I have met, consulted with the Office of Ethics, and have indicated any areas where I thought there would be an issue. And I will be recusing myself of any matters that would present any potential conflict.

The CHAIRMAN. Well, thank you.

Do you know of any reason, personal or otherwise, that would in any way prevent you from fully and honorably discharging the responsibilities of the office to which you have been nominated?

Ms. VERMA. I do not.

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

Ms. VERMA. I do not.

The CHAIRMAN. You are willing to do that?

Ms. VERMA. I am willing to do that.

The CHAIRMAN. All right.

Finally, do you commit to provide a prompt response in writing to any questions addressed to you by any Senator on this committee?

Ms. VERMA. I do.

The CHAIRMAN. Well, thank you.

Let me now just get into some questions. I know you are aware of the historic bipartisan Medicare Access and CHIP Reauthorization Act of 2015, which I had a lot to do with, or what is called MACRA. Among other things, the law got rid of the dreaded SGR formula and made improvements to how Medicare pays physicians.

And I am pleased that our work on the implementation of these changes continues to be bipartisan, both in how Republicans and Democrats in the Congress have worked together and how Congress had worked with the Obama administration. In fact, the Obama administration took great pains to engage physicians and other stakeholders through the initial implementation phase.

Now, it strikes me that this process of consultation early and often should be the rule and not the exception.

What is your view on how to engage stakeholders to arrive at the best policy decisions for Medicare and other CMS programs?

Ms. VERMA. Thank you, Senator. And I applaud Congress's efforts to pass MACRA. I think it is an important step forward, not only to providing more stability for providers, but also moving us towards better outcomes.

You know, in terms of stakeholders, I think that the most important thing that we can do is engage with stakeholders as quickly as possible on the front end and all the way through the process, understanding stakeholder perspective and what folks are going through on the front end, what their challenges are. And, as we are developing policies and programs, to have that open communication I think is helpful towards any successful implementation. It is not a one-time thing. It is not just on the front end. It is all the way through the process.

And even after the program is established, it is always important to have that dialogue with stakeholders, because they can tell you what is working and what is not working. And when you think of new ideas and you are thinking about implementing them, they can help you figure out whether it is going to work or not.

I know I have had that experience in my career, and I have always found it very helpful and an integral part of success.

The CHAIRMAN. As the baby boomer generation ages, the number of persons age 65 and older in the United States is expected to dra-

matically increase, fueling an increase in the demand for long-term services and supports.

Notably, Medicaid is the primary payer of these services. What changes, if any, should be made to meet the expected increase in demand while ensuring the fiscal sustainability of the Medicaid program?

Ms. VERMA. I think Medicaid is a very important program. It has been the safety net for so many vulnerable citizens.

When I think about the Medicaid program, I think about some of the individuals whom I have met. One person in particular I think about is a quadriplegic. He is on a breathing machine, and he requires 24-hour care. I think about the mother of a disabled child. And this is the face of the Medicaid program.

As we think about the Medicaid program and where we are today, I think that we can do better. We have the challenge of making sure that we are providing better care for these individuals, but the program is not working as well as it can. This is a very intractable program, it is inflexible; States are in a situation where they are having to go back and forth doing reams of paperwork, trying to get approvals from the Federal Government. And at the end of the day, are we achieving the outcomes that we want to achieve?

So as I think about the Medicaid program, I think there is an opportunity to make that program work better so that we are focusing on improving outcomes for the individuals who are served by the program.

The CHAIRMAN. All right. In 2014, I worked closely with Senator Wyden and leaders from the House Ways and Means Committee to enact a bipartisan, bicameral law called the Improving Medicare Post-Acute Care Transformation, or IMPACT, Act.

The IMPACT Act serves as a critical building block to achieve future Medicare post-acute quality measurement and payment reform.

Specifically, the IMPACT Act requires the collection of standardized data to help Medicare not only compare quality across the different post-acute care settings, but also improve hospital and post-acute discharge planning. And our goal was to produce data-driven evidence that Congress can use to debate the best ways to align Medicare post-acute payments that improve patient outcomes and save taxpayer dollars. And our intention was to ensure that we are able to do this type of thing.

We want to ensure that beneficiaries are receiving the highest-quality post-acute care services in the right setting at the right time.

Now, will you commit to working with me and members of Congress and this committee and the post-acute provider community on the implementation of the IMPACT Act?

Ms. VERMA. It would be my pleasure to work with the committee, stakeholders, and anyone else who is interested in making that program a success.

The CHAIRMAN. Well, thank you.

We will turn to Senator Wyden.

Senator WYDEN. Thank you very much, Ms. Verma. And thank you for your testimony.

I want to start with a comment you made that you were committed to coverage, which, of course, is what this is all about.

Unfortunately, what I have seen since the beginning of the year has been basically about rolling back coverage. And in fact, Congressman Price sat in your seat a couple of weeks ago and refused to commit to making sure that no one would be worse off in terms of coverage.

Now, the President said in his campaign, and I will quote, "We are going to have insurance for everybody. The American people are going to have great health care, much less expensive and much better." That is what the President said.

Yesterday, CMS did the exact opposite. The first rule to come out of the agency—the agency that you would head—after Secretary Price was confirmed meant less coverage, higher premiums, and more out-of-pocket costs for working families.

How would you square what President Trump said in the campaign with what CMS did yesterday?

Ms. VERMA. Sir, in terms of the rule that you speak of, I have not been involved in the development of that rule. Out of respect for the committee and for the nomination process, I have not been involved in that, have not been to CMS, so I have not been involved in that and I cannot speak to that.

What I can tell you is that I am committed to coverage. I have been fighting on this issue for 20 years. And I will continue to do that if I am confirmed.

Senator WYDEN. But I just read you quotes, and it is not like, you know, atomic secrets or classified materials. What the President said is very different than what CMS did yesterday.

And you read newspapers; you are a very informed person. It talked about cutting the enrollment period. I am looking at the headline, "cut the enrollment period in half," which really is going to limit our ability to get the very people we need most, the younger, healthier people.

So one more try. How would you square what the President said with what happened yesterday?

Ms. VERMA. I think the President and I are both committed to coverage. I cannot speak to the rule. I have not had an opportunity to review that. But again, I think the President and I both agree that we need to fight for coverage and make sure that all Americans have access to affordable, high-quality health care.

Senator WYDEN. What troubles me about yesterday is, once again insurance companies are coming first and patients come later. Tell me one thing you would change to put patients first.

Ms. VERMA. One thing that I would do is—I think what is very important is that patients be in charge of their health care, that patients get to drive the decisions about their health care, that they get to make the choices about what kind of health care plan works well for them.

I think it is important that our patients have access to quality coverage, to their choice of doctors and their choice of plan.

Senator WYDEN. Could you give us a specific on that? Because that is an admirable philosophy, but I still do not know——

Yesterday was good for insurance companies, and it was bad for patients. I would like to have a specific example, and we will keep the record open, of something you would do to put patients first.

And I respect the fact that you have articulated a philosophy, but I really want to know a specific about what you would do to put patients first.

Let us move on with respect to another area of responsibility you will have, and that is prescription drugs and Medicare, because we all know that these prescription costs are just clobbering families and seniors, the Federal Government, and a whole variety of stakeholders that you referred to.

As the Administrator of the agency, you are going to have an opportunity to address this problem. The President has been vocal on it. Again, give me a specific change to Medicare Part D that you would suggest to bring costs down.

Ms. VERMA. Well, I think that the issue of drug pricing is something that all Americans are concerned about. And the President is concerned about that as well. People want to make sure that when they need the drugs, when they're going through an illness—I mean, I think about my mom, I think about my neighbor Aidan, and when they need the drugs that they need, they want to know that they have access to them and that they are affordable. So I think we are all concerned about that specific issue.

Part D, I think, has been a good program. It has expanded access to medications for people who did not have them before. And I think the structure of the program in terms of how it puts senior citizens in charge of their health care, they can go on Plan Finder, go online——

Senator WYDEN. My time is up, Ms. Verma. I voted for Part D. I still have the welts on my back to show for it. I asked you for a specific change going forward that you would do to help seniors and others hold down their costs.

As you know, there is discussion of making changes so that Medicare could bargain. Is there one specific you could give me?

And the reason that the Medicare question is so important is, not only does this affect older people so dramatically, but your experience is on the Medicaid side, and I respect that. People have different experiences. So I very much would like to hear a specific on this key Medicare issue that you would actually be for.

Ms. VERMA. I would be for policies that continue to put senior citizens in charge of their health care, that put them in the driver's seat of making the decisions that work best for them so that they can figure out what plan covers the medications that they need, what plan is affordable to them and allows them to make the decisions about their health care and that gives them access to the medications that they need, that doesn't limit that in any way and that is affordable to them.

Senator WYDEN. My time has expired.

I still did not get a specific example. I happen to be for a host of things on transparency, on negotiation, on trying to make sure that we squeeze more cost savings out of the middle men.

I am going to hold the record open, but I have asked you for specifics in two areas: putting patients first and how you would hold

down the costs of Part D. Respectfully, I did not get a specific. We will hold the record open for it.

I think, Senator Grassley, you are going to call out names on your side?

Senator GRASSLEY. Got next. [Laughter.]

Senator WYDEN. That did not take much time.

Senator GRASSLEY. What I am going to talk to you about is things that have happened at CMS in the past. And hopefully, coming from an administration that wants to drain the swamp, I think I would expect changes to be made under your leadership in this agency.

And I would suggest that you probably cannot do anything about the suggestion I am going to give you to respond to the last question of my colleague, but if you would push doing away with pay-for-delay programs between brand drugs and generics, I think it would go a long ways to helping get drugs cheaper.

CMS has told me that it does not have much authority to do anything about some frauds committed against its programs, even if those actions are in CMS's own words, quote, unquote, "a clear violation of the laws."

And common sense tells me that if it is a clear violation of the law, CMS can do something about it. And if that is their attitude there, I would ask you to see whether the past interpretation is right by checking that interpretation.

But in a January 28th letter to me about the Medicaid drug rebate program, CMS said it could tell a manufacturer when its drugs are misclassified and then, quote, unquote, "attempt to reach an agreement." In other words, after the money has been stolen from the taxpayers, it takes some trouble to get it back, if you can reach an agreement.

But there are a lot of tools that the government has to fight fraud. And the most effective one we have is the False Claims Act. Since 1987 when I got that law in place, the Department of Justice has used the False Claims Act to recover more than $33.9 billion lost from just health-care fraud alone. But cooperation between the Department of Justice and the health-care program administrators is very important in these cases.

It seems like CMS could at least have picked up the phone and given the Department of Justice a heads-up when these manufacturers refused to cooperate and properly classify their drugs.

So a pretty simple question; it might even be called a softball question, but it is pretty important to me. Would you commit to proactively cooperating with the Department of Justice in fraud cases and to fully supporting the use of the False Claims Act to combat fraud on government health-care programs?

Ms. VERMA. I will absolutely do that. And I applaud your efforts on the False Claims Act. I think it has been an integral component of preventing fraud and recovering dollars when there is fraud. So I thank you for your service and your work on that.

Senator GRASSLEY. Next question: in the fall of 2016 and in January of 2017, I sent several oversight letters to CMS regarding the steps that it took to hold Mylan accountable for misclassifying the EpiPen as a generic under the Medicaid drug rebate program. CMS has publicly stated that it, quote, "expressly advised Mylan that

their classification of the EpiPen for purposes of the Medicaid drug rebate program was incorrect."

However, CMS has failed to fully respond to my oversight requests and refuses to provide records of communication with Mylan. CMS has also not been entirely clear as to what has to be done to correct drug misclassifications. Because of EpiPen's misclassification, the government and States are owed hundreds of millions of dollars from Mylan. Congress and the American people are owed answers.

So if confirmed, would you commit to fully responding to my oversight request and providing the requested records of communication between Mylan and CMS? I hope that is a short "yes."

Ms. VERMA. That is a short "yes."

Senator GRASSLEY. All right. In light of EpiPen's misclassification and potentially other drugs that have been misclassified under Medicaid, what steps will you take to ensure that drugs are properly classified under Medicaid?

Ms. VERMA. I think what happened with Mylan and the EpiPen issue is very disturbing. The idea that perhaps Medicaid programs, which are struggling to pay for those programs, that they could have potentially received rebates, is disturbing to me.

And so, if I am confirmed, I would like to review the processes in place there in terms of the classifications, in terms of brand and generic, to assure that that type of thing does not happen again.

Senator GRASSLEY. And what you just said you want to do, I want to do, and that is why I want those communications from CMS. I hope you can get them for me.

Ms. VERMA. Well, I will be happy to work with you on that, Senator.

Senator GRASSLEY. Senator Stabenow?

Senator STABENOW. Well, thank you very much.

And welcome. Welcome to you and your family.

First thing—there are many, many questions I have—but first, regarding Medicare, do you believe that Medicare programs should negotiate the best price for seniors on Medicare?

Ms. VERMA. I think that we need to do everything that we can do to make drugs more affordable for seniors. And I am thankful that we have the PBMs in the Part D program that are performing that negotiation on behalf of seniors.

Senator STABENOW. Do you believe we could get a better price if Medicare was negotiating as the V.A. does, as other private entities do to get the best price for seniors?

Ms. VERMA. I think that competition is the key to getting good prices.

Senator STABENOW. So is that "yes" or "no" on negotiation?

Ms. VERMA. I do not think that is a simple "yes" or "no" answer, because I think there are many ways to achieve that goal. And the goal is to make sure that we are getting affordable prices for our seniors.

I mean, if we look at the Part D program and the way the PBMs have negotiated this, we know that when there is a lot of competition, the price goes down. So I think we have to figure out ways—and I am happy to work with you on that—that we can increase our competitiveness and support the Part D program.

What I like about the Part D program is that it puts seniors in charge of making the decisions about the drugs that they need. Using the Plan Finder tool, they can go in there, they can put in the medications that they need, and then they——

Senator STABENOW. No, I understand that. I am going to stop you, just because I do not have a lot of time.

Ms. VERMA. Sure.

Senator STABENOW. Under the repeal of the Affordable Care Act, actually seniors would begin to pay more, because the gap in coverage for those who use a lot of medicine would appear again. So we have closed that, no gap for seniors, and that would reopen.

Do you support that as part of the repeal?

Ms. VERMA. I think that, as I said before, it is important to help seniors get the most affordable drug prices that they can get.

Senator STABENOW. Do you support returning to a gap in coverage for seniors under Medicare Part D?

Ms. VERMA. I support seniors having access to affordable medications and the medications that they need, that they choose.

Senator STABENOW. All right. Let me ask this now to follow up a little bit more on yesterday's decision regarding CMS.

One of the things that they decided to do yesterday was to cut in half the open enrollment period for people to be able to get insurance, from 3 months to 6 weeks. Do you support that?

Ms. VERMA. You know, I have not had a chance to review that rule. I was not involved in the development of that with respect to the process.

Senator STABENOW. Does it seem like a good idea?

Ms. VERMA. I am sorry?

Senator STABENOW. Does it seem like a good idea, from your standpoint, to shorten the amount of time?

Ms. VERMA. You know, I want to review the implications of that. I was not, as I said before, with respect to this process, I have not been to HHS, have not been to CMS, and have not been involved in the development of that rule. So I would look forward to reviewing that and would be happy to report back to you after I have had a chance to review that.

Senator STABENOW. When we look at another really important set of provisions in the Affordable Care Act—it is something I call patient protections—everybody with insurance, it does not matter who it is, has more ability right now to get the care that they are paying for through their insurance. It is not just the decision of the insurance company.

So there are a number of different things that folks can now count on. And one is having an essential set of basic health-care services that is defined so that insurance companies are betting that everybody knows there is a basic set of services, that as a woman you will get maternity care, that mental health will be covered the same as physical health, or substance abuse services, and so on. So there is a basic set of services.

Do you support having that basic set of essential services in our health-care system?

Ms. VERMA. I support Americans being in charge of their health care. I support Americans being able to decide what benefit package works best for them. I think it is hard to know. What works

for one person might not work for another person. And I think it is important that people be able to make the decisions that work best for them and their families.

As a mother of two children, you know, in a family, I know what we are looking for. But what I am looking for might not work for another family. And so I support Americans being in control of their health care and making the decisions that work best for them and their families.

Senator STABENOW. Do you believe that women should have to pay more to get prenatal care and basic maternity care, as a rider, as an extra coverage?

Ms. VERMA. You know, I am a woman, so I certainly support women having access to the care that they need. I have two children of my own, and I have appreciated that the services they want——

Senator STABENOW. Should we as women be paying more for health care because we are women?

Ms. VERMA. I think that women should be able to make the decisions that work best for them.

Senator STABENOW. But if the decision is made by the insurance company as to what to charge, how do we make that decision?

Prior to the Affordable Care Act, I have said many times, about 70 percent of the insurance companies in the private marketplace did not cover basic maternity care and basically looked at being a woman as a preexisting condition. Different kinds of health services that we need were not provided, were not viewed as essential services.

And that has changed now, where women have what are basic services for us covered as basic services, where we do not have to pay extra as a rider in order to get basic care.

And so I am just asking, do you think that makes sense?

Ms. VERMA. You know, obviously, I do not want to see women being discriminated against. I am a woman, and I appreciate that.

But I also think that women have to make the decisions that work best for them and their family. Some women might want maternity coverage and some women might not want it, might not choose it, might not feel like they need that.

So I think it is up to women to make the decision that works best for them and their families.

Senator STABENOW. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. As you can imagine, we are now having two votes. And there is nobody here to question, so I think what I will do is recess for about 15 minutes. Sorry to interrupt like this, but that is the life of a U.S. Senator.

And we surely appreciate you and appreciate your patience. And I appreciate the way you are answering these questions straightup, and your expertise really comes through.

So with that, I will just recess for about 15 minutes. Hopefully I can get to the second vote and be right back.

Ms. VERMA. Thank you.

The CHAIRMAN. We will revoke the recess, and we will turn to Senator Roberts.

Senator ROBERTS. Well, thank you, Mr. Chairman.

And congratulations on your nomination, Ms. Verma. Thank you for paying a courtesy call to my office. We had a very, very good discussion. You have a very impressive record with regard to Medicaid, more especially pushing for greater innovation and flexibility in the program.

I must say, your opening statement was not only relevant, right on point, but inspiring as well. Thank you for that. I think I would speak for all members of the committee. We need to make a copy of her statement available, Mr. Chairman, to virtually every member, maybe test them on it to see if we, you know, can bring things back together.

The CHAIRMAN. I agree with that, and we might do that. All right.

Senator ROBERTS. As co-chair of the Senate Rural Health Care Caucus, I am particularly concerned with how regulations coming out of your agency work or often do not work for our small and rural providers. We talked about that.

And I am also interested in how we harness their innovation to develop payment and delivery models that are better-tailored to their communities and their needs, given their low volume of patients and high number of Medicare and Medicaid patients. I know you are very familiar with that with your work in Indiana.

How do we work to include our small and rural providers in quality improvement programs without disadvantaging them due to the unique populations they serve?

Secondly, would rural-relevant quality measures or different data thresholds be more appropriate to encourage participation in certain value-based purchasing and/or pay-for-performance programs?

Ms. VERMA. Thank you for your questions, Senator. You know, rural health providers have very unique and special challenges. I mean, often they are the only providers in their communities that are providing services, and so when people come to them, they are dealing with a variety of different health issues. It is not just primary care and preventative care. It could be specialty care. And they do not always have access to those services.

The challenge for them is that even attracting a workforce and finding providers to come out to those regions is a challenge and it is difficult. And because they have those multiple challenges, it is difficult for them when there are lots of rules and regulations coming down from the Federal Government.

As a small-business owner and working with small physician offices, we sort of understand that it is difficult sometimes when they are on the front lines and they are trying to manage such very complex situations. To also deal with rules and regulations is difficult.

That being said, we want to assure that all Americans have access to high-quality health care. But I think we have to be very careful with our rural providers to make sure that we are not putting additional burdens on them that actually, you know, impact accessibility to care or quality of care.

So I think when it comes to rural providers, we need to support them through the process. We need to make sure that they have the appropriate technical assistance to get where they need to be

and understand that the demands they have on their time might impact their ability to implement those regulations.

Senator ROBERTS. I really appreciate that. I think we have 83, probably more today, critical access hospitals. And I know you have the same situation in Indiana. Thank you for your statement.

As a member of both the HELP and Finance Committees, as many of my colleagues are, we often see a disconnect between new and exciting therapies that are approved by the FDA and reimbursement policies from CMS.

Take biosimilars, for example. Last year, only one, one biosimilar, was approved by the FDA. And guidance documents were still outstanding. CMS proposed and then finalized a payment policy that could stifle innovation in this area.

How would you anticipate working with the FDA to ensure CMS is developing the best payment policies for patients, providers, and the taxpayer?

Ms. VERMA. Well, I think collaboration and coordination are critical within HHS. I appreciate Secretary Price and his leadership there. Careful coordination and collaboration between similar agencies or sister agencies are important.

I think being on the front end and discussing with them, understanding what their intentions are, what is coming down the pipeline, and making sure that CMS is prepared and coordinated with any efforts that the FDA has, is important.

Senator ROBERTS. I must tell you that, in the rural health care delivery system, in talking to many of my hospital administrators and the rural providers—you are in charge of CMS—the term used a lot in the past has been "it is a mess." I know you are going to fix that.

But there is CMS's Center for Consumer Information and Insurance Oversight; CCIIO, that is the new acronym. I was not aware of that. I thought I knew most of them. It has responsibility for developing and implementing policies and rules governing and administering the Affordable Care Act's marketplace.

What role do you see CCIIO playing under your leadership?

Ms. VERMA. If I am confirmed as Administrator, my job will be to implement the law. CCIIO is playing a role with the current law, and so I would look to Congress and its efforts around addressing the Affordable Care Act. And my assessment of the role of CCIIO will depend on what Congress decides to do with the Affordable Care Act. And so I will make that decision based on the ultimate outcome of Congress's decisions around the Affordable Care Act.

Senator ROBERTS. I must say, Mr. Chairman, that I am impressed with your statement. I know that we have had several Senators talk about unraveling Obamacare. We had an entire insurance company leave the market. We have another one describing it as a death spiral.

I think we need to see a rescue team to make sure that that bridge is still there, but build new bridges. And I think that would be my take on that.

Thank you so much for your testimony. And thank you for the leadership that I know you are going to bring to CMS.

Ms. VERMA. Thank you, Senator.

The CHAIRMAN. Well, thank you, Senator.

While we are waiting for other questioners, let me just ask a question.

One of the issues this committee has focused on over the past 3 years is the large backlog of Medicare appeals resulting from audits performed by CMS contractors. At the same time, improper payments pose a real threat to the financial well-being of the Medicare and Medicaid programs.

So what are your views on how to balance the need for robust program integrity and claims accuracy with the need to ensure timely payment to providers without causing them too much undue burden?

Ms. VERMA. Well, I think that that is a very important question. Fraud and abuse, if I am confirmed, would be a top priority. That is what I would call, you know, low-hanging fruit as we look at the Medicare program and assure its sustainability over the long term. And given the Medicare trustees' report about the future of Medicare and running out of money at some point, we just cannot afford to waste a single taxpayer dollar.

And so, if I think about fraud and abuse, and especially fraud prevention, it is looking to have an effort to really be on the front end, not waiting to do a pay and then chase, but really addressing fraud on the front end.

And so, as we are developing programs, we need to make sure that we are putting those procedures and policies in place so that we can identify fraud and abuse on the front end.

I think the issue that you raise in terms of the backlog and the burden that it puts on providers is something that concerns me. And we want to make sure, with CMS's policies, that we are not preventing providers from participating in the program and being active in it.

And the backlog and things like that have really made it difficult for providers when they are not getting paid for these types of issues. And so I think it is a balance that we have to strike with being aggressive on fraud and abuse and focusing our penalty efforts on the bad players without penalizing providers that are trying to do the right thing.

The CHAIRMAN. Well, thank you. States are increasingly moving their Medicaid programs into a managed care delivery system, with managed care now representing almost 40 percent of Federal Medicaid spending.

Now, in the last year, CMS released an updated regulatory framework for Medicaid managed care. What if any changes do you believe are important to Federal and State oversight of Medicaid managed care?

Ms. VERMA. Well, I think that managed care has been an important opportunity for States. It gives them the ability to set a capitation rate with providers and hold the managed care companies accountable for meeting that financial demand.

And it is also an opportunity to identify goals and outcomes and hold these companies accountable for the care and the outcomes that they provide.

In terms of the regulatory framework and the managed care role, I think that we probably need to move to an era where we are holding States accountable for outcomes, but having States go through

pages and pages of regulations—my question would be, for that regulation, what does it do to improve health outcomes for the individual?

I am all about wanting to make sure that we are being appropriate with our health-care dollars and managing resources effectively. But when we look at a regulation, is that regulation helping States improve health outcomes?

States will spend millions of dollars implementing that particular regulation. And I think we have to ask ourselves, what will we achieve?

So I think there are some important developments within the managed care regulation, but if I am confirmed, I would want to take a look at that to make sure that we are not burdening States with additional regulations.

The CHAIRMAN. All right. Let me ask you this. Your written statement alludes to providers struggling to deal with administrative burdens. And while we certainly need providers to be accountable for the care they provide and the associated government spending, it is crucial to minimize the regulatory requirements that take time away from treating patients.

Now, we have heard concerns regarding the very specific requirements that are a part of the Medicare and Medicaid Electronic Health Record Incentive Program. We also hear that many other requirements are unneeded or outdated.

So how do you think CMS could best go about the important task of reducing unnecessary regulations?

Ms. VERMA. Well, I think one of the places to start is by talking to doctors and having open communication and collaboration with physicians. If I am confirmed, that would be a priority for me: to touch base with our providers and understand the issues that are getting in the way of them being able to provide high-quality care to the patients that they serve.

I would want to identify the types of regulations and provisions that are causing providers perhaps to consider maybe not participating in the program. So I think I would start with that open communication and dialogue and work with them to understand what their concerns are.

The CHAIRMAN. Well, thank you.

I think I will turn to Senator Wyden for any questions he has.

Senator WYDEN. Thank you very much, Mr. Chairman.

And you know, again, Ms. Verma, I am just trying to get a sense of how you would approach some of these things. That is why I asked apropos of what CMS did—just one example, a specific example about putting patients first. Same thing with respect to, you know, Medicare Part D.

On this committee, as the chairman touched on, colleagues touched on, members feel very strongly about rural practices and rural patients, and we feel very strongly about making sure that we get MACRA right.

And when I am home in Oregon, I get asked about two key parts of the new payment system a lot. I get asked about virtual groups and the definition of "more than nominal risk." And people say, hey, what is this going to mean for the small and rural practice?

Now obviously, you know this is not dinner table conversation either. But for the doctors in rural Oregon, small practices, they say this is really going to tell us about whether we are going to get to succeed in this brave new world of payment systems.

So tell me a little bit about how you as Administrator would look at something like this. I mean, Senator Thune, for example, has also been concerned about the virtual groups. How would you go about structuring and implementing these virtual groups?

Ms. VERMA. I think that, you know, I think small providers, rural providers, in terms of MACRA, I think it is going to be a challenge for them. I think it is a worthy goal, but we are going to have to be supportive of them through the process of implementing it.

In terms of providers taking risk, and especially smaller providers, I think that that is a larger mountain to climb. I think they are going to be reluctant to take risk. When they are starting out, many small providers and rural providers do not have large financial reserves that the bigger health systems have.

And you know, in terms of putting them on the hook, when we think about health outcomes and holding providers accountable for outcomes, a lot of that also depends on patients. And I think thinking about strategies about how we can engage patients to be a part of that equation so that they have the same investment, they have some investment to work with their providers towards achieving outcomes——

But you know, in terms of smaller providers and rural providers taking on risk, I think that is going to be a formidable challenge.

Senator WYDEN. And on virtual groups, what is your take on, let us say, the most important thing to make them work?

Ms. VERMA. Well, I think that we have to continue to work with them to understand what their specific concerns are and try to address them. But I think at the end of the day those are going to be challenges that we are going to have to work through with them.

You know, what I have found is, listening to folks, understanding what their concerns are and trying to see, to the best of our ability, if we can try to address those concerns——

Senator WYDEN. And what about the whole question of nominal risk? And again, I want to keep this open-ended enough so this is not, you know, I want to hear about paragraph 3, line 2. I just want to get a general sense of how you would approach it, because this is what rural physicians and patients are going to talk to me about. I am going to have town hall meetings in a couple of days. So how about nominal risk?

Ms. VERMA. Well, you know, I think that this is the challenge here. I do not know that rural providers and small providers want to take risk at all. And I think that, you know, when we are designing these programs, we have to keep in mind their specific needs.

Taking on risk is something that insurance companies have done, some of the larger health-care systems have done. If we look at some of the ACO models, we know that very few providers, even large health-care systems, have been comfortable taking on risk. So

I think this is going to be a considerable challenge for the smaller providers. Some of them may not want to do that.

Senator WYDEN. So does that mean—when I listen to that, it sounds to me a little bit like Ms. Verma wants to keep fee-for-service.

Ms. VERMA. You know, I think fee-for-service, there are definitely some concerns with fee-for-service. That is rewarding volume over quality and outcomes. And so I am not suggesting that that works better.

I think that there is something to be said—and I support efforts to increase coordination of care and to hold providers accountable for outcomes. I think, though, in terms of also holding providers accountable for outcomes, it is another thing altogether to have them accepting risk.

Senator WYDEN. So let us do this like we did the other two questions. I would like in writing—because this is so important for rural practices, rural providers—I would like just even one specific that you would pursue to try to address these issues.

And the reason I am asking is because it is a big lift. There is no question about that. There is no question that trying to keep a rural practice open is a big lift.

But these are the questions that providers are going to ask me. When they see me, they are going to say, "Ron, you are on this committee; you deal with these issues. How is the government going to go about doing it?"

So I will have one additional question later, Mr. Chairman. But let us add that to the matter of the specifics, both with respect to putting patients first as opposed to insurance companies first, as we heard yesterday, and the pharmaceutical question where I would like a written answer.

And I think, given the fact that these matters are moving on a fast track, we are going to need to have your answers certainly within the next 3 days or so. All right?

I will have one additional question later, Mr. Chairman. Thank you.

The CHAIRMAN. Why don't you ask it now since——

Senator WYDEN. I think we only have a couple of more minutes on the vote. That is part of the reason that we have so few——

The CHAIRMAN. Is this the second?

Senator WYDEN. Yes, this is the second.

The CHAIRMAN. Yes, we both have to go, don't we?

Senator WYDEN. Mr. Chairman, if you are willing, we could do the vote. I have one additional question. I assume you will want to make a closing statement at the end. And I would like to too. And we also have some Senators coming back.

The CHAIRMAN. Right.

Senator WYDEN. So I think we will come back.

The CHAIRMAN. We still have 10 minutes on a vote here.

Senator WYDEN. We will come back.

The CHAIRMAN. All right. Well, let me use a little bit of this 10 minutes and ask another question.

There is great provider interest in participating in various Medicare projects that change the way payment is made to incentivize providers to change the way that they deliver care. Now, many of

these alternative payment arrangements are being run through the Center for Medicare and Medicaid Innovation. But others are being conducted independent of it, such as a good portion of the Accountable Care Organizations program.

And while all of these programs involve some type of formal evaluation, there is understandably great interest in knowing what works and what does not and as soon as possible.

What is your view to testing different Medicare payment approaches and how to best assess the results?

Ms. VERMA. I think—a couple of things. I mean, one, first of all, I would say that I support efforts around innovation. It is important that we are always trying to climb the highest mountain and that we are never satisfied with where we are, always trying to figure out how to do better, how to get better quality care, better health outcomes, improved delivery services. And so innovation is important.

But as we are looking at testing new ideas, I think that process has to make sure of a couple of things. We need to make sure that we are not forcing, not mandating individuals to participate in an experiment or some type of a trial that there is not consent around. I think that that is very important. So that is what I would say first off.

In terms of evaluation, evaluation is an important component. Obviously, that is why we are doing it: to understand whether that can be transferred or whether it can be used for a larger population or for policy of the program.

So evaluation is a critical component of that. That needs to be set up on the front end. It needs to be before the evaluation goes full scale. I think it should be done on a small population or on a small frame first before it is expanded. But that evaluation needs to be done on the front end and all the way throughout the process.

And I think as it is expanded or before it is expanded, those results should be shared with stakeholders and I hope with members of Congress. And there should be discussion about that before that becomes formal policy.

The CHAIRMAN. Well, thank you. Let me just ask one more question while we are waiting for some of the Senators to get back, and then I am going to have to go vote again.

Seniors have a choice whether to enroll in the traditional government-run Medicare fee-for-service program or in an alternative private insurance option called Medicare Advantage. According to CMS, approximately 18.5 million people, roughly 32 percent of all Medicare beneficiaries, are estimated to have signed up for a Medicare Advantage plan this year.

Now, generally, Medicare Advantage plans offer extra benefits, such as dental, vision, hearing, and wellness or require smaller copayments or deductibles than traditional Medicare. Sometimes seniors pay a higher monthly premium to get these extra benefits. But also, they are financed through the plan's savings.

Traditional Medicare does not limit the patient out-of-pocket spending for Part A and Part B services, causing some seniors to buy supplemental Medicare coverage called Medigap insurance.

People who do not have retiree coverage or who cannot afford Medigap supplemental insurance find Medicare Advantage plans

offer the extra benefits traditional Medicare does not cover and protect them from higher-than-expected out-of-pocket spending.

I had a lot to do with Medicare Advantage, by the way, so I will tell you that in advance.

Ms. Verma, can you commit to working with this committee and Congress to preserve and strengthen the successful Medicare Advantage program?

Ms. VERMA. I can. And it would be my pleasure to work with you on that.

I think that the Medicare Part C or Medicare Advantage has been a great program for seniors. What I like about it is that it is offering choices for seniors. They have the ability to figure out, again just like in Part D, what plan works best for them.

And the fact that it provides them the opportunity to have additional benefits, vision and dental services, I think, is very important. And the fact that it just provides more choices for seniors is an important component of the program.

So I would be happy to work with you on that.

The CHAIRMAN. Well, thank you.

Now, I notice that Senator Crapo is going to pass and Dr. Cassidy is here, so I am going to call on him next. And then I have to have staff follow up on this. All right.

Thank you for being here. I do not think I am going to be able to even get back, but we will just continue on until we get this hearing over.

Senator Cassidy?

Senator CASSIDY. We are both familiar with the data from MIT, the National Bureau of Economic Research, that showed the expansion in some States, that Medicaid expansion, not necessarily de-expansion, but Medicaid expansion really did not do much for outcomes. But the Healthy Indiana Plan seems to have had an effect upon outcomes.

Can you just comment on the nature of the structure of giving folks health savings accounts, requiring some input on their part, what that did both for expenses as well as for outcomes?

Ms. VERMA. Thank you for your question. It is always a pleasure to talk about the Healthy Indiana Plan, so I appreciate the opportunity.

The Healthy Indiana Plan is about empowering individuals to take ownership for their health. We believe in the potential of every individual to make decisions about their health care.

Senator CASSIDY. Now, I am going to interrupt you occasionally. There are some who say that health savings accounts, even prefunded, are not appropriate for those who are lower-income, suggesting they lack the technical ability or the sophistication with which to handle that.

But you are suggesting that the Healthy Indiana Plan, which I assume was, what, 100 to 138 percent of Federal poverty level——

Ms. VERMA. The Healthy Indiana Plan actually starts at the very lowest level of the poverty spectrum, so even people at zero percent or people who do not have income.

Senator CASSIDY. And they were enrolled in your plan as well.

Ms. VERMA. They were enrolled in our plan. What we find is that, just because individuals are poor does not mean that they are

not capable of making decisions. It does not mean that they do not want to be able to have choices and that they should not have those choices.

They are very capable of making decisions about their health care. And just because somebody is poor does not mean that they should not have choices and that they are not capable of making decisions that work best for them and their families.

Senator CASSIDY. So what I find intriguing about your plan, again—it is my understanding that E.R. visits were down, whereas in other States, when there was an expansion, there was a bump up in E.R. visits. And in the Healthy Indiana Plan, E.R. visits actually went down.

But concomitantly, I think you have data that outcomes improved, unlike the National Bureau of Economic Research, which found that outcomes did not improve. Do you want to elaborate, please?

Ms. VERMA. Yes. So the Healthy Indiana Plan, what we have seen is that the individuals who were actively engaged and making contributions to their health savings accounts had better outcomes. They had more primary care, more preventative care; they had lower E.R. use. They were more satisfied with their care. And we also showed that they had better adherence to the drug regimens that their doctors prescribed—so, all across the board.

Senator CASSIDY. A skeptic might say that, wait a second, by splitting it between those who made contributions and those who did not, you ended up with two different populations, that the ability to contribute reflected something underlying. I assume you all did a regression analysis of some sort. Did you find that to be the case?

Ms. VERMA. No. What we found is that the individuals who were actually making contributions toward their care, they were actually sicker individuals, so they had more complex illnesses. And yet, when they were making contributions toward their care, they actually had better health outcomes than individuals who were healthier to start with.

Senator CASSIDY. Really? So the folks who were sicker, theoretically with less disposable income—they certainly cannot work as much—nonetheless valued health care more. This reflected in their contribution, but there was a positive correlation between adherence——

Ms. VERMA. That is correct. They had better drug adherence. They had more primary care, more preventative care.

And these were not by small margins, I would add. You know, when we look at primary care and their preventative care, these were margins of about 20 percent for primary care and preventative care. So there were significant differences for individuals.

And I think what it shows is that we can empower individuals to take ownership for their health, and that people, just because they do not have income, does not mean that they are not capable and that they do not want to have choices.

We believe in the dignity and the potential for individuals to make decisions. And they are happy to do that, and they have better outcomes.

Senator CASSIDY. Now, I think the key factor here—I think in the academic literature, they speak of the "activated patient." You are using the term "empowered," but that seems to be the critical factor here.

To what degree is the patient empowered as they partner in their health? To what degree does she participate? Both related to each other, but that, in turn, ends up—again, causative outcomes, lower cost.

Ms. VERMA. That is exactly what we have seen. And even with the Healthy Indiana Plan, if we compare the Healthy Indiana Plan to other States, we have actually been able to do it. It costs less, and we have been able to reduce the number of uninsured in our State at higher levels than other States that have run more traditional programs.

So we have done it at a lower cost, had better outcomes, and reduced the number of uninsured.

Senator CASSIDY. But inevitably, there is a Federal role in this. And so is it possible that you could reduce the Federal role to zero and have a plan such as yours still be viable in a State with a high poverty rate?

Ms. VERMA. So in Indiana, negotiating the Healthy Indiana Plan and being able to achieve the waivers, I mean, this was something that Governor Daniels actually asked the Federal Government: "Can we use the Healthy Indiana Plan for the Medicaid expansion?" And he even asked this before the Supreme Court decision, which made it optional.

So he wrote that first letter in 2010, and it took the Federal Government almost 5 years to make a decision about whether this program could work.

So I think that, you know, that is something that we need to look at or that I would hope that Congress would want to work on, because that type of back-and-forth——

Senator CASSIDY. So the approval process can be made more efficient. But again, there are Federal dollars which would seem essential as well.

Ms. VERMA. Exactly.

Senator CASSIDY. Thank you. I yield back.

Senator ISAKSON [presiding]. Thank you, Senator Cassidy.

Senator Nelson?

Senator NELSON. Good morning. I enjoyed talking to you on the telephone.

Do you support turning the Medicare program into a voucher system?

Ms. VERMA. I support the Medicare program being there for seniors. People are making contributions into that program.

Senator NELSON. So would that include the voucher system?

Ms. VERMA. You know, I think that I do not support that. I think what I do support is giving choices to seniors and making sure that that program is in place.

What we have seen is, I think, efforts—I think there is a lot of concern about the future——

Senator NELSON. Excuse me for interrupting. I did not understand. The fellow who is now the Secretary of HHS had taken a

position as a Congressman supporting the voucher system, turning Medicare into a voucher system. Do you support that?

Ms. VERMA. So let me back up with my answer here and try to explain this a little bit more. You know, I think that what I have seen in terms of different types of options that are being discussed around Medicare, those are borne out of individuals who want to make sure that that program is around. I want to make sure the program is around for my kids.

And so, you know, what we know from the trustees' report is that——

Senator NELSON. So to make sure that it would be around, you are saying that you would consider alternatives.

Ms. VERMA. You know, I think that I am not supportive of that. I think that we need to make—but I think it is important that we look for ways of making sure that the program is sustainable for the future.

Senator NELSON. All right, let me give you one of the alternatives. One of the alternatives is to increase the age from 65 to 67. Do you support that?

Ms. VERMA. You know, I think ultimately what direction that we go into is up to Congress. As the Administrator of CMS, my job would be to carry out whatever Congress decides is the best course of action for the Medicare program.

And I would hope that we would work towards making the program more sustainable so that it does exist for future generations and that it is a program that provides high-quality care, accessible care, and gives seniors options.

Senator NELSON. So you do not think you should be involved in policy? You said, "Leave it up to Congress."

Ms. VERMA. I think it is the role of the CMS Administrator to carry out the laws that are created by Congress.

Senator NELSON. All right, let me ask you—there is another availability that seniors enjoy, which is that the doughnut hole was closed, which means that seniors in Florida spend about a thousand dollars less out of their pockets by drugs being reimbursed through Medicare.

So in the Medicare prescription drug program—now I know that you just had a question close to this, but what I need to know is, do you support the provisions in the ACA that closed the coverage gap to make prescription drugs more affordable, or closing the doughnut hole, "yes" or "no"?

Ms. VERMA. I support efforts to make the availability of medications affordable and accessible for seniors. I want to make sure that they have choices about the medications that they need and that that coverage is affordable to them. So I support efforts in terms of——

Senator NELSON. I am running out of time. I am just trying to get clear your thinking on this. So if a senior, since you support making drugs affordable to seniors, but if a senior had to pay a thousand more dollars out of their pocket per year for their drugs, is that something that you would support?

Ms. VERMA. You know, ultimately what happens with the doughnut hole is really up to Congress and how we move forward on this.

In the role of Administrator, my job would be to implement the policy or the legislation that is developed by Congress.

Senator NELSON. All right, so back to the policy by Congress. All right.

Here is one you may be able to answer. How about—as you know, on dual-eligibles, the Federal Government gets a discount from the drug companies for the dual-eligibles who are eligible through Medicaid until they get to 65, then they get their drugs from Medicare, but then there is no discount.

Would you support requiring drug manufacturers to pay drug rebates to Medicare for the dual-eligibles?

Ms. VERMA. Yes, as I said before, I support efforts to make drugs more affordable to seniors. And I think this is an issue that we are all concerned about, the President is concerned about as well, that we need to make it more affordable.

And I would look forward to working with Congress on strategies that can help it be more affordable while maintaining accessibility and ensuring that our seniors have access to the drugs that they need.

Senator NELSON. I am sorry that you have the constraints put on you so that you cannot answer these questions forthrightly. And those are the questions that I can tell you senior citizens are begging to hear the answers to.

Because if you had approached this as candidate Trump had, saying he was going to protect Medicare and Social Security and not have any cuts, your answers would be different, and they would be clear. But you have chosen to go the route that you have, and I am sorry that you have those kind of constraints.

Thank you, Mr. Chairman.

Senator ISAKSON. Thank you, Senator Nelson.

For the benefit of the members of the committee, the order remaining of those who have not asked questions is Isakson, Brown, Heller, and Scott. And that is the order we will go in, unless someone comes in who is still on the list.

And I will take my time now.

First of all, and I will just make a statement, you do not have to really comment unless you want to, but words are a strange thing sometimes. They can be used depending on what you want the ultimate goal to be.

In the Veterans' Administration—and I am the chairman of the Veterans' Affairs Committee—3 years ago Republicans and Democrats joined together to create what is known as the Choice Program in terms of V.A. health care benefits to try to expedite veterans getting services and to maximize the use of the V.A. and the private sector.

In the first year of that program, there were 2 million more appointments filled through the V.A. than had been in the previous year, and all those were because the access to the private sector gave the veterans better access. So the veteran had the choice and used the private sector and the Veterans' Administration to do it.

I think that is a good example of where choice made a difference, delivered health care, did not change the cost, made accessibility better, and made the program work better. So "choice" is not a bad word. Choice can be a very good word. And the Congress did that

3 years ago in August, and it has been a program, it has worked ever since.

Are you familiar with that program?

Ms. VERMA. I am not familiar with that program. But I do believe I agree with you that choice is critical. When there are choices, then there is competition, and we have folks who are trying to attract our beneficiaries to the system. So choice and competition are very important to driving better quality in outcomes and lower cost.

Senator ISAKSON. In Georgia, we have 1.9 million Georgians on Medicaid; 1.3 million of those 1.9 million are children. Half of the children born in my State are born with Medicaid benefits.

Are you committed, as we go through the reforms and the enhancements and the improvements of the program, to make sure we keep children foremost in our mind for coverage?

Ms. VERMA. I am, absolutely. As a mother of two children, I certainly understand the importance of health care for children. And one of the things that I am reminded of in my work with the Medicaid program and with the CHIP program—I remember hearing a story about a woman. And it was after the CHIP program had been passed. But she talked about how she had a child who was an infant, probably 1 or 2 years old, maybe an infant, about 1 year old, and she had gone to the doctor, and her child had an ear infection. And the doctor gave her a prescription just for a simple antibiotic to treat the ear infection.

And she went home that night and she had a choice to make. If she filled the prescription, she would not have enough money to pay for meals for the whole family. And so she made the painful decision of not filling the prescription and feeding her family for the whole week.

And what happened to that child is that, because of his untreated ear infection, he ended up losing his hearing and going deaf. And so I am always reminded of that story. And that child now needs lots of different services to help him through, and that is something that could have been prevented.

So it is very important that children have access to high-quality services. That is really important so that we do not have situations like that.

Senator ISAKSON. Thank you for your answer.

Are you familiar with the 21st Century Cures Act that passed?

Ms. VERMA. I am.

Senator ISAKSON. It is a great piece of legislation. And Senator Warner and I had one of the provisions in that bill, which is very important to us, on home health care. It provided for reimbursement for durable medical equipment under Part B and home infusion and home health care through Medicare.

And it is something we wanted to make sure we had, because under the ACA home health care was almost totally removed from being reimbursed. And having had personal experience, I know home health care is the best environment to deliver health care services and the least costly to the government.

I hope you will look closely at that 21st Century Cures Act and the home infusion provisions we put in it, to see to it they get implemented.

Ms. VERMA. I would be happy to work with you, Senator, on that. And I agree. I think the Cures Act—and I applaud Congress for coming together on a bipartisan basis to pass that law—I think it is going to have a tremendous impact on the health care of Americans. And I appreciate your efforts on that and would be happy to work with you.

Senator ISAKSON. And lastly, just really quickly, when I was in the State legislature years ago, the biggest thing we fought was a lot of fraud in Medicare and Medicaid. And that still is a problem today.

I am very familiar with it from the business I was in. The verification of eligibility is very important to make sure you have minimal fraud and minimal waste. Are you committed to using the commercial resources that are available in the private sector to verify eligibility where that is important?

Ms. VERMA. I am absolutely committed to that.

Senator ISAKSON. Thank you very much.

Senator Brown, I am sorry to tell you, but Senator Menendez slipped in, so he is going to be one ahead of you.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Ms. Verma, congratulations on your nomination.

One of the successes of the Affordable Care Act was the establishment of a nationwide benefit standard called the essential health benefits package. And one of my amendments to the law, which was adopted by this committee, was to ensure that coverage for behavioral health services, like therapies for children with autism, are available in every plan purchased through the marketplace. That is to ensure that a child in Georgia or Indiana or New Jersey has equal coverage and equal access to the care that they need.

I have heard from countless families about the anxiety they have over losing access to critical autism services through a change in the essential health benefits that allows insurance companies to deny coverage, which is especially acute in States that lack a State-based requirement.

Do you agree that a child's access to insurance that covers a condition like autism should not be based on what State they live in?

Ms. VERMA. I appreciate your question. My husband is a child psychiatrist, so he deals with those issues on a day-in and day-out basis. So I certainly understand the concern.

I have been advised by the Office of Government Ethics not to participate on issues regarding mental health services because my husband is a psychiatrist and that it could impact his practice. And so——

Senator MENENDEZ. Well, with all due respect, autism is not a mental health issue. Autism is an illness where we are still trying to develop the essence of its cause. But at the end of the day, I use it by way of example. Are you suggesting that you cannot tell the committee a simple answer to the question that it should not matter where you live in the Nation, that in fact you should have access to the same coverage as any other child?

Ms. VERMA. I think that all Americans should have access to the health-care services that they need. However, in the issue that you

are asking me to comment on, I have been advised by the Office of Government Ethics not to participate on matters that, because of my relationship, my husband's practice, to not offer——

Senator MENENDEZ. Did they define to you the list of things that fall under this category?

Ms. VERMA. He does treat children with autism, and so they have asked me not to engage on matters that involve his practice.

Senator MENENDEZ. That is pretty amazing to me.

Let me ask you this. As you know, Congress has to act this year on a package of Medicare extenders. Which of those Medicare policies do you consider to be your top priority?

Ms. VERMA. I have not reviewed that particular regulation, but I would be happy to review that, if I am confirmed, and work with you on that.

Senator MENENDEZ. Well, let me just say, Medicare is a big part of what CMS deals with. And I would have thought that, in preparation for this hearing, you would have a sense of these extenders that are almost on an annual basis or a biannual basis. But it is the heart of giving us a sense of what you as the potential Administrator would be advocating as it relates to Medicare.

Your role as the CMS Administrator is more than just executing simply the laws of the country, which certainly you would. But it is also a policy development-heavy position that the President and the Secretary of Health and Human Services and the Congress rely on when drafting laws that ultimately would have impact in your parameters.

So you have no idea as to which one you consider the most significant?

Ms. VERMA. At this point, I would want to review that before I gave you my opinion on that particular area.

Senator MENENDEZ. Let me ask you this. During our meeting in my office, you referred several times to so-called able-bodied beneficiaries as we were speaking about Medicaid.

Do you believe that low-income and working-class individuals who gained access to Medicaid thanks to the Affordable Care Act's expansion should be eligible for Medicaid?

Ms. VERMA. I think that when I think of——

Senator MENENDEZ. I think that is a simple "yes" or "no," because my time is limited. Do you believe that they should have access to Medicaid eligibility?

Ms. VERMA. I think that all Americans should have access to high-quality health-care services.

Senator MENENDEZ. That is not an answer. That is not responsive to my question.

Ms. VERMA. But I think——

Senator MENENDEZ. I am asking about Medicaid specifically——

Ms. VERMA. When I think about the Medicaid program, I think about it almost in two different parts. There is the part of the Medicaid program that serves the aged and the blind and the disabled. That is a very different population than some of the able-bodied individuals.

But at the end of the day, all Americans should have access to high-quality, affordable health-care coverage.

Senator MENENDEZ. Well, I will just simply say, "unresponsive to my questions." I cannot vote for someone to be the Administrator of one of the most significant agencies that affects the health care of people in the country if I cannot glean from you in an open hearing under oath what your answers are to these questions. I have no answers, and so it is very difficult, very difficult. And I have not reflexively been against the President's nominees. I have voted for several of them. But you have to give me more than that. I hope that your responses to written questions will be more enlightening for me.

Thank you, Mr. Chairman.

Senator ISAKSON. Senator Cantwell?

Senator CANTWELL. Thank you.

Congratulations on your nomination. We had a great discussion about innovation in the Pacific Northwest, and so I wanted to follow up on that.

But to my colleague's point, you know, there has been a lot of discussion about block-granting Medicaid. Are you in favor of that?

Ms. VERMA. You know, when I think about the Medicaid program, I will say that the Medicaid program as a status quo is not acceptable. I think that we can do a lot better for the many people who depend on this program. We are talking about disabled individuals, quadriplegics, people who are developmentally disabled, mentally disabled, and we can do a better job than what we have today in the program.

We know that we are not delivering great health outcomes. There has been study after study that shows that even people who do not have Medicaid have better health-care outcomes.

Senator CANTWELL. Do you think there are problems with block-granting Medicaid?

Ms. VERMA. I think that, you know, when I look at this, I think we need to think about how we can make this program work better. The status quo is not acceptable. This is the United States of America, and we can do better for our vulnerable populations. We can hold States accountable for producing better outcomes.

Senator CANTWELL. So are you endorsing block-granting?

Ms. VERMA. I am endorsing the program being changed to make it work better for the citizens who rely on it.

Senator CANTWELL. So you are not endorsing block-granting? I am just trying to understand, because this is the debate du jour as far as I am concerned. And I know that several of our colleagues, probably those in the House, are very adamant about this.

And so I am just trying to understand where you are on that question, whether you either are for it or against it or have concerns about it or endorse it. It is a spectrum, so I am giving you a little more room than my colleague gave you.

Ms. VERMA. Well, I appreciate that. Thank you. You know, what I support is the program working better, and whether that's a block grant or a per-capita cap, there are many ways that we can get there.

But at the end of the day, the program is not working as it should. When you have one State spending $4,000, you have another State spending $15,000 for the same population, can we show

that the outcomes are better; can we show that that individual had accessibility to high-quality care?

What we know is going on at the State level is that, you know, in terms of accessibility, one-third of doctors are not taking Medicaid patients. And that means for a disabled person that when they are sick, they call the doctor, and some of the doctors will not even take them, and the doctors who are taking them—they are having to wait for a long period of time to get care.

I mean, I think we can do better for these people. And I support efforts to get us there.

Senator CANTWELL. All right. Well, I would say this. This whole notion of capitating or block-granting, we know what the results of those programs have been. We have numbers here that it has resulted in a 37-percent cut. So if you just extrapolated that out, unless you assume that you have these States that would step up and cover those populations—my colleague Senator Hatch was talking earlier about the increase in population. The increase in population is what is driving the cost.

So coming up with a better strategy for that population, like rebalancing that I had a chance to talk to you about, is way more cost-effective. In our State, we saved $2.5 billion by taking people out of nursing home care and putting them in community-based care. But trying to capitate or say we are going to block-grant it ends up—you know, if you just said to my State, well, and the State did not come up with anymore funds, if you applied that same 37 percent, you would be cutting over 100,000 people in King County off, or you would be cutting 43,000 people in Spokane off.

I calculated the numbers, again just in extrapolation, and with that 37-percent reduction that other block-granting programs have received over the last 15 years, it would be like cutting a million people in Ohio off of Medicaid unless the State came up with more money.

So my point about this is, I hope you will be much more an advocate for the innovation in Medicaid, that instead of trying to nickel-and-dime poor people on a copayment or administrative cost, come up with the strategies, like rebalancing, that give people real opportunities to deal with this population, save cost, and keep people in a better, healthier situation.

So that is why I have grave, grave concerns about this notion of block-granting Medicaid or the capitation, as you mentioned.

Ms. VERMA. Well, you know, I agree with you. This is what it should be about: innovation. But what is going on in the Medicaid program today is that we have a very inflexible system when States are trying to do creative things.

And I agree with you in terms of rebalancing incentives and giving Medicaid beneficiaries the option of being served in the community. That is something that we should support and we should do.

But the way the system is set up is that States have to go to the Federal Government for any routine changes. Anytime they want to do something innovative and creative, it can take years to get a waiver done. And so we need to create a Medicaid program that allows States to be innovative and to have that flexibility so that they can focus on producing better outcomes for individuals.

And I, you know, I strongly do not want to see anyone not get health services. We are talking about the most disabled and vulnerable people in our population. And we can do better. We should be able to deliver better outcomes for these individuals and hold States accountable for accessibility and high-quality coverage. This is not about kicking people off the program. This should be about improving outcomes.

Senator CANTWELL. Well, we will have many more chances. My time has expired, but I just hope you will remember: innovate, do not capitate. Innovate.

Thank you, Mr. Chairman.

Senator ISAKSON. Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

I am going to follow up on Senator Cantwell's points, because I think the essence of her comments is absolutely accurate.

And, Ms. Verma, first of all, welcome. You are a product of my State of Maryland in education, and we are very proud of your accomplishments. It is nice to have your family here.

And I want to talk about minority health and health disparities in this country. Part of the Affordable Care Act was to put a focus on that. We now have a National Institute for Minority Health and Health Disparities. And there is a good reason, because historically minorities have been discriminated against in our health-care system.

We look at health-care results on diabetes, heart disease, hepatitis, HIV/AIDS, infant mortality, and other indicators, and we know we have a problem. And we have been making progress on that problem, and that is why I want to refer to Senator Cantwell's point about resources.

Resources are important. And I wish every policy decision we make in this committee and we make in Congress and make at the White House was driven by what is the right policy results. But far too often, it is driven by the budget numbers. And that is the reality; that is what we deal with.

And Senator Cantwell's point is that, if you move to block-grant the Medicaid program, the odds are it is going to fill a budget number, not fill a policy-driven objective. And who is vulnerable? The most vulnerable people in our society.

In Maryland, almost 70 percent of the Medicaid population are from communities of color. That is in my State of Maryland—70 percent. So when we expanded the opportunities for Medicaid under the Affordable Care Act, it made a big difference.

You may be familiar with the Greater Baden Health Center in Prince George's County. You are familiar with that community. I have been visiting that center for many years, and they are now able to provide mental health services and pediatric dental services and give access to care in a vulnerable community because of the expansion of Medicaid. And if we were to go to a program that is innovative but does not have the resources to implement, vulnerable people are going to get hurt.

So I just want to get your understanding as to the importance of resources. We are not going to improve our health-care system by telling people of means that they cannot spend money on health

care. They can get the health care that they need. It is the vulnerable population that is going to be challenged.

And as tough as budgets are here, budgets in Annapolis and other State capitals around the Nation are even tougher. Medicaid is such a large part of the State budget that when you say, well, we are going to innovate, but we need to invest to innovate, they do not have the money to invest to innovate. And then they have to look at, well, let us eliminate dental or let us eliminate the essential benefits that Senator Menendez was talking about.

So tell me how you are going to advocate for the poor, how you are going to advocate for those who are challenged in our system?

I do not know all the answers of the Indiana system. You and I had a chance to talk about it, and I applaud you for looking for innovation in your State. But I know that some interpret it to mean that those copayments that some have to pay, they do not have the resources to pay. And then if they do not pay, they are put into a system where they are denied certain benefits that they desperately need.

So I am interested as to how you see this system being fair to our most vulnerable.

Ms. VERMA. Well, first of all, I would say I have fought for coverage, for better outcomes for vulnerable populations, my entire career, starting with individuals with HIV and AIDS, working with low-income mothers to improve birth outcomes.

The issues that you raised around minority health are near and dear to my heart. I am a minority, and I understand that things are different. You have different cultural norms that impact how care is delivered and the types of advice that we give to individuals who are minority. So I certainly understand that.

You know, you talked about the Healthy Indiana Plan and making sure people have resources for their health care. You know, we looked at in the Healthy Indiana Plan—it was all about choices. We believe in the individual dignity and the empowerment of individuals to make their choices about their health care. And what we found is that when we gave people those choices, they made good choices and they had better health outcomes.

We saw emergency room usage go down. We saw individuals having more primary care and more preventative care.

Senator CARDIN. And of course, that is what we are seeing under the expansion of Medicaid in the State of Maryland with many more people insured. We are seeing less use of emergency room care, much more preventive health care, because we now have more people in the Medicaid system, about 250,000 more in our State.

So yes, the expansion of third-party coverage is critically important, but the quality of third-party coverage is also critically important. If you do not have preventive care, if you do not have pediatric dental, we know what happened. We know what happened in our own State of Maryland in 2007 with a tragic death.

So I appreciate that we are looking for innovation, but if you do not have the basic coverage, if you do not have the ability to provide the essential services, it is the vulnerable who are going to suffer.

Ms. VERMA. Well, I do not want to see the vulnerable suffer. Like I said, I have been working on that particular issue my entire career. I have done this on the local level, creating programs in Marion County for uninsured individuals, and I have done that on the State level. And if confirmed, I will continue that fight.

Senator CARDIN. I thank you.

Thank you, Mr. Chairman.

Senator ISAKSON. Thank you, Senator Cardin.

Senator Brown, you finally made it.

Senator BROWN. Thank you. Thank you, Mr. Chairman.

Thank you for your willingness to serve, Ms. Verma. Nice to see you again. And thanks for coming to my office and speaking.

I was a little disturbed with Senator Nelson's question about Medicare eligibility age at 67 or even 70, as your future boss has sponsored legislation on, at least at 67, and he was not willing to tell the committee that he had changed his mind or was opposed to it.

And on voucherizing or privatizing Medicare, I was concerned when you said it is up to Congress. Of course it is, but I would hope that you would—I am not asking this as a question, but I would hope that you would look at CMS as a platform to, one, tell your boss, the Secretary of HHS, and your ultimate boss, the President—who has said he would not do those things in the campaign, but then he nominates Congressman Price—but I would hope you would use that as a platform to stand up against those two things, because they are devastating to working-class Americans.

A couple of questions. The first question is simple. Governor Kasich recently named a new Director for the Department of Medicaid, former Ohio legislator Barbara Sears. Governor Kasich, as you know, extended Medicaid in Ohio; 700,000-plus people now have Medicaid coverage. Ohio's former Medicaid director, John McCarthy, he had an excellent relationship with CMS.

My question is—this one is the easy one—I would like to ensure this positive working relationship, and I would like to ask you to commit to sitting down in person with Director Sears and perhaps, if she chooses and you choose, a group of Medicaid administrators from around the country, to discuss my State's and their States' priorities and concerns when it comes to the Medicaid program.

And I would like to ask you to do that in the first few months on the job.

Ms. VERMA. That would be my pleasure to do that. I feel strongly about working with States——

Senator BROWN. All right, good. Thank you. All right.

Ms. VERMA [continuing]. In an open relationship and partnership.

Senator BROWN. Thank you.

During our meeting, you spoke glowingly about CHIP and what it has done. In 2010, Congress improved CHIP by streamlining enrollment processes and increasing outreach efforts and other things. We now have 95 percent of children in America who have affordable, comprehensive health insurance. What is not to love about that?

Secretary Price mentioned in his hearing that he would support an 8-year—8-year—extension of CHIP, of the current CHIP program.

It is important that when we upgraded CHIP in 2010 and streamlined it so it is a clean law now and easily understood—do you agree with Secretary Price that Congress should act quickly to pass an 8-year extension? And do you agree that that should be an 8-year extension of the current CHIP program to provide certainties for families and State budgets?

And please give me a "yes" or "no." Pretty simple, 8 years and clean CHIP.

Ms. VERMA. I support the reauthorization of the CHIP program and agree with Congressman Price that we need to do this to the fullest extent possible, and I look forward to working with Congress on that. I have two kids of my own.

Senator BROWN. All right. But the questions were more precise. Do you agree to the 8 years that he suggested?

Ms. VERMA. I support the reauthorization as long as possible.

Senator BROWN. All right. Eight years would be possible.

Ms. VERMA. Eight years or more.

Senator BROWN. I know it is up to Congress, but, I mean, what you do not either want to acknowledge or do not understand is, your recommendation to this Congress—you can say it is up to Congress. Of course, ultimately laws are, but your recommendation to Congress matters. If you and Secretary Price would say we want 8 years' extension and you would also say we want a clean extension, not a rollback, but what we had in 2010, what the present law is now, it would really, really matter.

And I think you would get every Democrat and you would get most Republicans, and that would take that off the table. It would take the uncertainty out of all these programs where we just kind of limp along, extending them a year or two or three or five at a time.

So I ask you again, will you recommend 8 years, and will you recommend a clean CHIP extension?

Ms. VERMA. I will recommend and support the reauthorization of the Children's Health Insurance Program for as long as possible. I think it is very critical that children have access to high-quality services.

You and I talked about this in your office, about my experience with this. So I support children having access to health coverage.

Senator BROWN. It would have been important to me more if you had said "yes" and "yes," but I appreciate the answer.

Beginning March 8th—let me ask you about another issue—hospitals will be required to give Medicare Outpatient Observation Notices to applicable Medicare beneficiaries as required under the NOTICE Act, which Congress, I am sure you are aware, passed just last year.

If confirmed as the CMS administrator, will you commit to aggressively enforcing those notice requirements for hospitals, "yes" or "no"?

Ms. VERMA. If I am confirmed as the CMS Administrator, it is my job to follow the law and to implement the programs as designed by Congress.

Senator BROWN. All right. The MOON notice, it is an important first step towards giving beneficiaries additional information, but it does not fix the issue of observer status, the underlying 3-day stay requirement. Hospitals are increasingly caring for Medicare beneficiaries as outpatients under observation status as opposed to admitting them as inpatient patients. While the classification of a hospital stay does not affect the level of care that a beneficiary receives, it has significant repercussions for the 3-day requirement and for Medicare coverage of significant care.

Do you support changes to the 3-day stay requirement?

Ms. VERMA. That is something that I would want to review and would look forward to working with you on that.

Senator BROWN. Do you have opinions of the 3-day stay requirement?

Ms. VERMA. I would want to review that in more detail.

Senator BROWN. Do you know what it is?

Ms. VERMA. I do know what it is——

Senator BROWN. Tell me a little about it.

Ms. VERMA [continuing]. But I would like to review that at this point and would be happy to work with you on that.

Senator BROWN. All right. Secretary Price, who apparently knows more about the observation status issue, raised it during his confirmation hearing. He specifically mentioned he would like to work on improving this rule. I assume you would work with him on that.

So can you give me any thoughts on what you would do at CMS to improve the 3-day requirement?

Ms. VERMA. Well, I think we need to work with providers on this. I know that there have been some issues there in terms of, you know, skilled nursing facilities and the impact of the rule on patients' ability to get in with that. So I would want to review that more carefully and would be happy to give you my comments.

Senator BROWN. All right. That was less than satisfactory, but I appreciate the effort. Observation status is a huge concern for beneficiaries across my State. And we get calls, as I am sure in Indiana some of your counterparts who were doing Medicare got calls. But I know that Senator Cardin, Senator Nelson, and others have been working this issue for years. And I hope we can work on it. Thank you.

Thank you, Mr. Chairman.

Senator ISAKSON. Senator Heller, I apologize, but Senator Thune slipped in under the transom, so I am going to have to go to him next.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman. And I hate it when that happens when I am down here, so my apologies.

Ms. Verma, thank you for being here. Welcome and thank you for your willingness to serve.

I know this has been touched on already, but I wanted to follow up because, when the MACRA final rule was released last November, I was concerned about the decision to delay implementation of virtual groups.

And then Acting Administrator Slavitt indicated that details were being worked out and that CMS was soliciting feedback from

physicians. The rule stated that implementation would not come until 2018. Well, being from South Dakota, I am continuously concerned with how we roll out new payment systems in rural areas.

Will you make it a priority of yours to ensure that virtual groups are timely and effectively implemented?

Ms. VERMA. I would be happy to do that and happy to work with you on that issue.

Senator THUNE. And how do you plan on engaging with those rural and sole practitioners to ensure that this is a viable option that they can take advantage of?

Ms. VERMA. I think that the rural providers and frontier providers are in very unique situations. And when we are thinking about policies, we need to engage with them on the front end to understand what their concerns are before policies are rolled out to make sure that we are understanding the impact on them.

You know, things that work well in an urban community do not necessarily work well. And I think sometimes living in DC, we do not have that understanding. So any time I think we have a policy, we need to work with rural providers, with frontier providers, on the front end to understand what their concerns are and what the potential impact could be.

And then, once something is out there, we need to make sure that we have that continued collaboration and communication so that if there are problems and if there are issues, we can address them in a timely way so that we are not impacting patient care and that we have a commitment to providing high-quality care and access.

Senator THUNE. Yes, I am glad to hear you say that. Additionally, the GAO had recently released a report, in fact it was in December, that lists the hurdles that small and rural practices may face when trying to participate in MACRA's new payment models.

As CMS moves away from fee-for-service and toward rewarding quality, I want to ensure that rural providers in my State will be able to participate in new and innovative methods that increase quality and reduce costs.

Aside from the previously mentioned virtual groups, the last question is, how would you go about ensuring that small and rural providers have access to these programs?

Ms. VERMA. Well, I think it is critical that we make sure in rural areas and frontier communities that we have that high-quality health care. And again, it goes back to collaborating with them.

These programs, I think, have enormous promise to deliver high-quality care and move us in a different direction, but we need to work with those providers on the front end to make sure that they can handle these new regulations and rules.

What I find is that, in the rural communities and frontier communities, I mean, they are stressed in providing care. They have a lot of enormous burdens. And we need to be careful that rules and regulations do not prohibit them from providing high-quality care.

And when you are out there on the front lines and you are trying to provide care, having to deal with a lot of rules and regulations can be difficult. And so we need to be supportive of them by providing technical assistance, making sure that we are available for

communication, and support them throughout the process of implementation.

Senator THUNE. I would like to turn just quickly to one other issue, and that is the meaningful use program for electronic health records.

Given the program's somewhat rocky track record, what do you believe is the future of the meaningful use program at this point?

Ms. VERMA. Well, I think that electronic health records have enormous promise. And I think they are helpful for physicians in terms of prompts, in terms of doing data and evaluation, but it has been a rocky start.

I think, as a patient, I have gone to the doctor's office and even seen signs in the waiting room that say, you know, we are going to be delayed or it is going to take a while because we are still getting used to electronic health records.

I have been in the room with my doctors where they are staring at their computer instead of looking at me as I tell them about my health-care issues. And so we need to make sure that it is working and it is working for providers and patients.

Interoperability—you know, if we are going to have electronic health records, then we should make sure that they fulfill their promise so that if somebody goes to the emergency room, even if they were in a different hospital or a different provider system, that the doctors can pull up the information and that they have those tools about what medications the person is on. And so we need to make sure that they are fulfilling their promise and not being more burdensome.

You know, I think there is a lot of potential there, in terms of prompts. I mean, I hear that physicians like the ability to, when they are talking to a patient, be able to say, well, what pharmacy do you like, and immediately send that script. So there is a lot of value there.

But we need to make sure that it is also fulfilling its promise and that it is giving us the things that it is supposed to do, so when you go show up to an emergency room, you actually have all that information. And sometimes I know we have come up short on some of those things. So that is something where I think we need continued efforts around that.

Senator THUNE. All right. Final point. I look forward to working with you. I mentioned in our discussion, our meeting, better coordination between the Indian Health Service and CMS. That is an issue that we have had lots of issues and problems with in my State of South Dakota. And I hope that we can make a lot of headway there. So thank you.

And thank you, Mr. Chairman.

Senator ISAKSON. Thank you, Senator Thune.

Senator Heller?

Senator HELLER. Mr. Chairman, thank you.

Senator ISAKSON. Your time has arrived.

Senator HELLER. Terrific, terrific. [Laughter.]

Ms. Verma, congratulations to you and also to your whole family who is there behind you. Your kids are very patient. I notice that Shaan is getting a little fidgety, so maybe we need to hurry up just a little bit. [Laughter.]

But we are glad you are here and glad the family is here also.

Twenty percent of the State's population in Nevada is on Medicaid and another 15 percent of the population is on Medicare. And we discussed in my office how important it is for you to strengthen and protect these programs and how critical that is for the State of Nevada. I just want you to know I appreciate the conversation that we did have in my office.

And like everybody else, I would assume on this committee that everybody is a strong supporter of Medicare. And I share that.

And I will say also that I have not supported, will not support legislation that does weaken Medicare.

So before I get started, Mr. Chairman—and I am not quite sure who is playing Mr. Chairman at this point—I would like to submit for the record a letter that I received from the Speaker of the House in the Nevada legislature and also the majority leader.

I asked Secretary Price if he would——

Senator WYDEN [presiding]. Without objection, it will be made a part of the record.

[The letter appears in the appendix on p. 62.]

Senator HELLER. All right, terrific.

All right, let us go to a couple of questions. I want to maintain the conversation that we have been having here on Medicaid today, if you do not mind.

Nevada, as you are probably well aware of, is one of 32 States that chose to expand eligibility for the Medicaid program. Numbers since the expansion: Nevada Medicaid enrollment increased from 350,000 to over 600,000. As of July 2016, Medicaid enrollment in Nevada is over 200,000 people greater than what was projected before the expansion.

I have had numerous conversations. I had a conversation with the Governor. I have had conversations with State employees. Our State legislature, our hospitals are all very seriously concerned about moving this program to a block grant.

They are concerned that they will not have the appropriate funding to cover clearly all 600,000 Nevadans who are on the program and who are on Medicaid. And they are concerned that they do not have the staff to implement such significant changes.

They are also concerned that with a part-time legislature, the State will not have the time needed to establish drastically different Medicaid programs. So I guess my question to you is whether or not you are sympathetic to these concerns for these block-grant States, these expanded block-grant States like Nevada. And so you understand those concerns?

Ms. VERMA. I absolutely understand those concerns. I have worked with States for almost 20 years now, so I understand the concerns. I understand the State budgets. I understand the States that have expanded and the States that have not expanded.

You know, I think in terms of the Medicaid program, for me, the opportunity is about improving health outcomes. We are talking about a very vulnerable population. You know, these are individuals who—you know, it is a safety net. Medicaid is a safety net. They do not have another place to turn. If you are disabled, if you are a quadriplegic, if you are paralyzed, Medicaid is the program.

But what we have today does not work well. I mean, we know that studies after studies have shown that the outcomes are not great. We know that States are spending different amounts of money, $4,000 in one State, $12,000 in another State, and do we know that we are getting better outcomes? Do we ask these individuals about their care?

So, you know, I think that the conversations that we are having should all be around improving health outcomes and trying to do a better job here. I do not want to be about hurting States. That is where I come from, and that is what I understand. I have worked with a lot of different Governors, and I understand, you know, where they are in terms of State budgets. And there is not a whole lot of extra money.

But I think this is about giving States, putting States in a leadership role so that they can manage their programs better. I think that States are closer to the people whom they serve than the Federal Government and they have a better understanding of what can work in their State than the Federal Government.

You know, I think we have heard from some of the Senators today about rural areas, for example. You know, they have special challenges there in frontier areas. So some of the things that are coming down from Washington in terms of a one-size-fits-all approach do not always work. And I think States should have that flexibility to design a program that works better for the people whom they are serving. And they are better positioned to make those decisions than we are in DC.

So I think that this is an opportunity to create flexibility so that they are not having to go to the Federal Government every time they want to make a simple and routine change.

And what we have seen in the Medicaid program is that, you know, because it is so inflexible, there is not a whole lot that you can do in designing your program. And so what States do often when times are tough is, they cut provider rates.

In 2012, we had over 44 States either freeze or cut provider rates. And that has an impact on access to care. But they are doing that not because they do not care about the people whom they serve; it is because the program is so inflexible.

So I think an opportunity to give States more flexibility is an opportunity to improve health outcomes for individuals.

Senator HELLER. So is it fair for me to say that you are pushing a block-grant approach?

Ms. VERMA. I am pushing an approach that improves the Medicaid program, because I do not think the status quo is acceptable. I think we can do better for disabled people and for people who are very vulnerable and who are dependent on this program.

I think we can do better improving outcomes and making sure that individuals are not receiving health care in the emergency room and that their health is actually improving.

Senator HELLER. All right. My time is up. Are block grants on the table or off the table?

Ms. VERMA. I think anything should be on the table that can improve health outcomes for this very vulnerable population.

Senator HELLER. All right. So it is my understanding then that block grants are on the table.

Ms. VERMA. You know, I think block grants, per-capita caps, anything that we can do to help improve outcomes and create a level of accountability for States—I think we should explore all of those options. And I look forward to working with Congress on this.

Senator HELLER. Ms. Verma, thank you.

Mr. Chairman, thank you.

The CHAIRMAN. Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

Thank you, Ms. Verma, for being here. We are excited about your opportunity that lies before you.

I am the co-chair of the Sickle Cell Caucus. And every Valentine's Day I have a chance to go to the Children's Hospital at the Medical University of South Carolina and hang out with some of the kids who have been hospitalized several times a year, oftentimes for cancer or a chronic condition that can consistently resurface. As a matter of fact, the sickle cell disease has accounted for somewhere around 246,596 emergency room visits as a principal diagnosis in 2014.

The gentlelady behind me, Jordan, who is a student at my alma mater, Stall High School, she has been in and out of the hospital as a youngster, 15 years old, a number of times.

And having an opportunity to see the challenges that so many families face and the necessity of Medicaid as their primary provider, raises a lot of questions. And one of the questions I would love to get your input on is, what are your thoughts about innovative things CMS can do to reduce readmissions, decrease costs for providers and payers, and improve care for those with sickle cell and similar chronic conditions?

Ms. VERMA. You know, I think one of the things that we can do is that, you know, anybody on the Medicaid program, they are in a vulnerable situation, whether it is being aged, blind, disabled, or having a disease-specific condition. They are completely dependent on this program.

And as I said in my opening statement, sometimes this is a matter of life and death for these individuals. They have no place to turn. So we need to assure that we have the best possible program, better quality, better outcomes.

And I think that those decisions and the ability to do that should come at the State level. And the State has a better understanding of the delivery system and of the citizens they serve. So they are in a better position to make those decisions.

So in terms of, you know, readmissions and really focusing on outcomes, I think on the Federal level it is important to establish what are the expectations of the program. What are we going to hold States accountable for? You know, it should be quality, and it should be accessibility.

Senator SCOTT. Have you found, working with the State of Indiana, that there were a couple of things that you thought worked really well on the State level that you would like to see on the national level?

Ms. VERMA. Well, you know, first I would say that every State is different.

Senator SCOTT. Is different, I know.

Ms. VERMA. And you know, as I worked with States—you know, I am known for the Healthy Indiana Plan—people would say, do the Healthy Indiana Plan nationally. Every State has a different opinion. I have never actually had a State that wanted the Healthy Indiana Plan, you know, in entirety. They looked at it, they took things that they liked about it and applied them and they designed their own programs. So I think that that is why we need to have a program that is flexible and allows States to do what works best for them.

Senator SCOTT. There is no doubt that most of us consider the 50 States the laboratories of our democracy, where good things happen. Without any question, having a national model where we have taken the best ideas from those States is an important part of your responsibility moving forward.

I know that you have consulted with a number of States, including South Carolina, for programs like the pay-for-success financing models where Medicaid basically pays for performance, which I think is a fantastic model.

What do you see as the future of the pay-for-success model in Medicaid? And what is the appropriate role for CMS in that process?

Ms. VERMA. Well, I think that the concepts around that program are critical. I think you know, instead of micromanaging the process, we need to say definitively, here are the outcomes that we are driving towards. I think right now what we are doing is, we are managing the process, we are not holding States accountable.

You know, in terms of South Carolina, one of the very innovative things that they have done there is the application of the nurse/family partnership for low-income families or for low-income first-time mothers. And having that home visiting program, I think, is an excellent idea.

But again, that program, you know, had a lot of thought. It took many, many, many months to get that program approved through CMS. And that is a great example of how the State has this idea and it is innovative, it has been proven in other communities. And to be able to do that on a ready basis without having to go through that long process of approvals, I think that is an important idea, the importance of having State flexibility.

Senator SCOTT. Thank you, Mr. Chairman.

Thank you, Ms. Verma.

The CHAIRMAN. Well, thank you, Senator.

Senator Enzi?

Senator ENZI. Thank you, Mr. Chairman.

First of all, I want to thank you for the opportunity I had to meet with you before. I do want to ask unanimous consent that a statement that I have could be put in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Enzi appears in the appendix on p. 55.]

Senator ENZI. We do have an outstanding nominee before us who has had a good life outside of Washington. And she does not need to be subject to personal attacks or made into a symbol of partisan discord.

I really get distressed at the way these hearings go, where we try to push for some things in actual legislation that ought to be reviewed. And again, be reminded that she gets to make good suggestions, but we get to pass the final laws.

And since I met with you, I have read a lot more about you. You have not just studied Medicaid and Medicare and other health situations, you have actually been hands-on; you have done things. You have actually helped States to make their process work better. You have a track record. And it is very impressive.

I think around here that makes you overqualified, unfortunately.

You have not been cutting people off of Medicaid and Medicare. You have experience that has worked at the State level.

You and I talked about frontier and rural and that has been emphasized here again, because we have several States represented that are frontier and rural.

Wyoming has the lowest population in the Nation, and we have also had a devastating economic hardship because the last administration did not like energy. And we are the energy State. And so our State has had to make some very tough decisions.

A year ago, the legislature, in their biannual budgeting, had to cut 8 percent. And when the session finished, they found out that that was not enough, so the Governor had to cut 8 percent. And now they are into the second year on the biannual budget. And when they came back, they found that revenues are down so much they have to cut another 8 percent.

And that presents a lot of problems, not just in the health-care area, but across the board, and education particularly is being devastated by that. But they are working through it, and they will get it.

When I met with you, I also talked about Medicare's competitive bidding program. And we talked about some of the unique challenges of rural and frontier States.

I want to know if you will be willing to continue to have a dialogue about how that competitive bidding process can ensure that people actually get what they think they are getting and what we think that we are buying.

In your view, is it going to be important for CMS to look at avoiding putting in place the one-size-fits-all programs?

Ms. VERMA. I think that is absolutely critical. And you know, working for States, what I see is that they are all different, their delivery systems are different, their patient population is potentially different. So a Federal one-size-fits-all approach does not always work.

And I think what you are bringing up in terms of the competitive bidding is an excellent example where we have some providers who are being paid—they are rural providers—but they are being paid at a rate that is more appropriate for an urban area.

And so I think that is the type of policy where we need to understand how that is going to impact a rural provider or a frontier provider on the front end and have that discussion so that we do not have problems later on down the line.

And if we are having issues, then we need to be responsive to that, because we want to make sure that we are not impacting ben-

eficiary access and that seniors and other folks who depend on CMS programs always have high-quality care and accessibility.

We do not want to see that our policies and our programs are actually preventing providers or that we are losing providers or that they do not want to see Medicaid or Medicare beneficiaries anymore. We should be very careful with policies so that we are not pushing providers out of the system, but that we are actually attracting providers to the program.

When we attract providers to the program, we are giving our seniors, Medicaid beneficiaries, we are giving them more choices. And when they have choices, that is what is going to drive quality in the system and hopefully lower costs.

Senator ENZI. Again, you have demonstrated what you talk about. You are not just talking about something that you have studied in a book or that you wrote a Ph.D. paper on.

As you know, dual-eligible individuals are a complex and expensive patient population. They affect both Medicare and Medicaid. So are you committed to working at the Federal level and with States at the State level to address the mounting financial concerns about the dual-eligible population?

Ms. VERMA. I think we must address that issue. I mean, as we have an aging baby boomer population and we have more and more folks going to be coming into the Medicaid program and Medicare program, we are going to need to have closer collaboration and make sure that we have the incentives in place to manage that program well and to assure that we are providing comprehensive, coordinated, quality care to those individuals.

I think it is difficult and confusing for them when they are on two different programs. And we need to make sure that those programs work well for those beneficiaries.

Senator ENZI. Thank you. And thank you for your outstanding presentation. And your family has to be really impressed, as am I, with your capability of answering and your vast knowledge. Thank you.

Ms. VERMA. Thank you, Senator.

The CHAIRMAN. Thank you, Senator Enzi.

The ranking member would like to ask a question or two, and then we will wrap it up.

Senator WYDEN. Thank you, Mr. Chairman. I do have a couple of questions and a quick wrap-up.

But let me also say that I very much appreciate how this hearing has been handled by you. You have made it clear that Senators get to ask the questions that are important, and that is the best bipartisan tradition of the Finance Committee.

The CHAIRMAN. Thank you.

Senator WYDEN. And as we move to wrap up, I just want to make that clear.

I have two questions for you that remain, Ms. Verma. One stems from this horrible tragedy you described where the family was forced to choose between putting food on their table or paying for a prescription to treat a child's ear infection. And the family, as you stated, a horrible account, chose food, and the child lost his hearing permanently.

What I have been told about the Healthy Indiana Plan that you designed is, if you had an individual who was making barely $12,000 who had the same kind of choice to make and chose not to pay their premium, they would be cut off from coverage for 6 months. So that individual would not get treatment for an ear infection or other such condition.

Is that correct? This is what I have been told, and I would just like you to tell me if that is correct or not.

Ms. VERMA. The Healthy Indiana Plan is about empowering individuals to take ownership for their health.

Senator WYDEN. With all due respect, just is that correct? Because we looked at the figures with respect to poverty, and, as I understood it, at $12,000 that person would be cut off. Is that right?

Ms. VERMA. The way the Healthy Indiana Plan works is that people who are above the poverty level, above 100 percent of the poverty level, make contributions into their health savings account. They make those contributions into their savings account, and they get monthly statements so they can see how that money is being spent.

If they complete their preventative health-care services, then they have the ability to roll over that amount that is in there in their savings account to offset their contributions.

If they have not completed their preventative services, they can still roll over, because that contribution that they are making is theirs and they own that.

In terms of what you indicated, if somebody does not make a contribution into their account or chooses not to make that contribution, just like it is in the Affordable Care Act, just like it is in the exchanges for the same population, individuals make contributions. They have 30 days to make that contribution. If they do not, they are terminated from coverage, and they cannot reenter until the open enrollment period.

So that is the exact same coverage, that is the exact same policy. In fact, the policy that we have in the Healthy Indiana Plan gives people 60 days——

Senator WYDEN. Whoa, whoa, whoa, whoa. There is a 3-month grace period in the ACA.

Ms. VERMA. There is a 30-day period where they continue your health coverage, but after that they suspend payment. So the individual actually does not have payment for their health-care services, and then they cannot reenter the program until a special enrollment period.

With the Healthy Indiana Plan, they actually have a 60-day grace period before they are terminated from the program.

Senator WYDEN. I am going to ask for this in writing. But we have reviewed this, and if they make $12,000, they are terminated. And I am going to ask you that in writing.

Let me go on to the ethics question. This was reported in *The Indianapolis Star*—I guess that is the big paper in your State—that while you were running the State of Indiana's Medicaid program, you and your consulting firm were paid millions of dollars by companies that did business with the State, including Hewlett-Packard and Milliman and Maximus and Health Management Associates.

And these companies provided financial, actuarial, administrative, and management services to Indiana Medicaid.

So the question became, the Indiana ethics regulations on conflicts of interest do not technically apply to you because you were a contractor and not a State employee.

But my question deals with essentially basic ethics principles, because it is hard to see how it is okay to basically orchestrate the State's health programs and then get paid by the contractors the State hires to carry out those very programs.

So let us set aside Indiana law. We understand that, I understand that those Indiana rules do not technically apply to you because you are a contractor.

But how is this not a conflict, because you were sitting, in effect, on both sides of the negotiating table?

Ms. VERMA. Let me start by saying that I hold honesty and integrity and adherence to a high ethical standard as part of my personal philosophy. That is for me. I demand that of my employees, and I set that example for my own children.

In terms of the issues that you raise, in Indiana we sought an ethics opinion, so we sought counsel on this to make sure that there were no issues. On a practical level, on a day-to-day level, we were not negotiating for HP. And what we were doing for HP was helping HP develop communication materials for when they were putting out system changes so that people understood what those changes were. So we were helping them with communications materials.

What we were doing for the State was around policy and helping them develop programs. And so there was no overlap.

When there was, when there was sort of the potential or when we were working on programs, we would recuse ourselves. So we were never in a position where we were negotiating on behalf of HP or any other contractor with the State that we had a relationship with.

We were transparent. The State knew about our relationships. I think that they issued a statement indicating in a response to *The Indianapolis Star* article that they were aware of our relationship, we disclosed that relationship, and on a practical, day-to-day level we did not engage in anything that would, you know, put us in a situation where we were supervising their work, negotiating their contracts. And we made that very transparent on the front end.

So if there was ever an issue—you know, I have been in meetings where we were talking about contractors, talking about implementing a program, and when it came to a vendor that we had a relationship with, I would recuse myself, I would get up and leave the meeting so that there was never any issue.

And I think the State has spoken on this. And the work that we have done with HP and these other vendors has extended over three separate Governors and over six Secretaries of Health.

Senator WYDEN. So the recently ousted head of the State agency administering your contract told this paper, *The Star,* that you once attempted to negotiate with State officials on behalf of Hewlett-Packard while being paid by the State.

So let us do this, because obviously there are differences of opinion. My concern was, it was not just one company. It was not just

Hewlett-Packard, but it was the wide array of companies that I listed: Milliman, Maximus, and a wide variety of services.

And my concern is, it is very clear that Indiana ethics rules do not apply to you in a technical sense because you were a contractor. No dispute about that. But it sure looks to me like you were on both sides of the table as a lot of money was being allocated.

And I think that really leads me to my last kind of point for today, Ms. Verma.

You have been asked a lot of questions. And my own sense is—and I have listened carefully to my colleagues—these were not "gotcha" questions. These were questions that were appropriate given the fact that, if confirmed, you are going to head an agency that is involved with a trillion dollars of spending and the health care of 100 million people or thereabouts.

And I think these questions were designed to get a sense of how you would approach them. And I felt very strongly—I enjoyed our conversation, and I decided I was going to try to give you as much real estate as I could in getting a sense of how you would approach them. That is why I asked the question about pharmaceutical prices, which is huge and so important to people.

And I said, I am going to ask Ms. Verma to give me one example, just one example of what she would do if confirmed in this position. And we did not get it in that area and in the rural area and in a variety of others.

So the chairman will take us through the rules for getting the questions for the record, but I am going to be reviewing those questions and responses very carefully. Because what I am troubled about today is, for questions that I thought were appropriate for a job like this, a trillion dollars' worth of spending, we are not really getting much of a sense of how you would approach them.

And I think that this committee needs answers. I think the public needs answers. And I will look at your written questions very carefully and look forward to talking with your further.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I want to thank Ms. Verma for appearing here today. This hearing is an important part of our committee vetting process. And I must say that, not surprisingly, you, Ms. Verma, have acquitted yourself very well.

I look forward to Ms. Verma being reported out of the committee and being confirmed by the Senate. And my goal is for this to all happen expeditiously.

It is critical that we get a strong, skilled leader in as CMS Administrator. It is essential to our efforts for collectively addressing our Nation's many health-care challenges.

Our current Administrator, who is not confirmed, had all kinds of conflicts, but we allowed him to go forward, a very bright guy who had a lot on the ball. And here you are as somebody who really has proven to be a tremendous leader in health care, not just in Indiana, but as an example to the rest of the States. And all I can say is that you will be a strong, skilled leader as CMS Administrator.

Now, it is essential for our efforts for collectively addressing our Nation's many health-care challenges that we get you there.

Senator WYDEN. Senator Portman is over there.

The CHAIRMAN. Oh, Senator Portman, do you still have some questions? [Laughter.]

I did not notice that you came in. I am ready to wrap up.

Senator PORTMAN. I am not very noticeable, I guess, Mr. Chairman.

I apologize, Mr. Chairman. I have been here twice, listening dutifully, and I have had separate hearings going on at the same exact time, so I have been bouncing back and forth. But I would like the opportunity to ask my questions. I have not had a chance to do that yet.

The CHAIRMAN. Then go ahead; proceed.

Senator PORTMAN. Thank you, and I apologize.

Thanks for your patience mostly, Ms. Verma, to your children who have been very patient. I have been watching them. Amazing. At their age my kids never could have done that.

So I heard a lot of the back-and-forth earlier. And let me just go to some of these issues.

First of all, I like what you are saying about patients taking more responsibility for their own health and how you can have a health-care system that encourages that. I think we talked about innovation earlier. Part of the innovation has to do with that. We want people to lead healthier, stronger lives, and part of that is providing that incentive within our health-care system.

We talked about leveraging technology and innovation. I like that. And many of us in our States are doing some things that are innovative.

As you know, the State of Ohio has an innovative health-care director whom I know you have worked with before. And a lot of this is about taking the existing dollars and using them more effectively to create better care. And I think that is a great opportunity, frankly, in a health-care system that is in need of more innovation.

And the technology part can be exciting; it can also be very expensive. So it has to be dealt with appropriately.

You said more State flexibility. And later you talked about holding States accountable for health outcomes—so looking not at the input as much and the volume, but looking at the output and the quality. And I think that is something where you are going to find a lot of agreement on both sides of the aisle here.

You also made the comment with regard to Medicaid that it sometimes can take years to get a waiver. And I have to say it is worse than that. Sometimes you cannot get a waiver. And as you know, because you were involved in putting together Ohio's waiver, we were not able to get a waiver to be able to give the State the flexibility that it wanted to be able to provide more innovation, better quality care, more holistic care, focusing more on prevention and wellness and getting people into the health-care system, not just when they have an emergency, but to have a better health outcome by having primary care physicians, and so on.

And that is something that concerns me, that it is not just about how it takes too much time often to go through this process, but

literally we cannot get these waivers sometimes. And the Obama administration HHS rejected the Ohio application.

The Healthy Indiana Plan was accepted, and you were very involved, not just in developing that, but in implementing that.

So if you could just speak briefly about what is the best thing about the Healthy Indiana Plan. Is it some of these characteristics I talked about earlier or others? And how could that be taken nationally? And then I want to talk to you about Medicaid expansion specifically.

Ms. VERMA. All right. You know, I think about the Healthy Indiana Plan, and what it has done is that it gives dignity to individuals. It empowers them. It recognizes their potential to fulfill their dreams. We do not assume just because somebody is poor that they do not want choices about their health care, they do not deserve choices, that they do not want to be involved, that they are not capable of making decisions.

And what we have found is that when we do that, when we create a situation, they are actually more engaged in their health care and their engagement leads to better outcomes. It leads to lower emergency room usage, more primary care, more preventative care, higher satisfaction, and better drug adherence.

Senator PORTMAN. All right. Now, that is what I want to hear, because that is what we should all hope for, that people have access to affordable care and that the results are, you know, better health outcomes because they are taking more responsibility for their own health and have the ability to do that, including access to primary care.

So here is the situation in Ohio. We have about 200,000 people who get coverage through the exchange, 212,000 as of yesterday, but we have over 700,000 people in Medicaid expansion. So when people talk about the Affordable Care Act in Ohio, they talk about it in terms of some of the mandates on small businesses, some of the issues obviously that have resulted in higher costs to provide health care, the higher premiums.

We have gone up 91 percent in the individual markets just in the last 4 years; 82 percent for small businesses. I mean, you know, people just cannot afford it.

But there is a lot of focus here in Washington on the exchanges, which are important in Ohio, but frankly in Ohio, what is more important for us is those over 700,000 people who are in expanded Medicaid. And again, you have talked a lot about this today and what you might support and not support in terms of how you give more authority and responsibility back to the States.

So that is my question for you. I am very concerned that we not move forward too quickly with the replacement and leave those people behind. I am also very supportive of a better system, including much more State flexibility, along the lines of what Governor Kasich wanted with his waiver request that was rejected.

So help me to understand how we can ensure that we do provide coverage to these people, particularly in my State. You know, the prescription drug, heroin, now fentanyl issue is huge. And the treatment that is provided to people in Ohio is often now through Medicaid expansion. And we want people to get into this treatment. Again, that provides them better health outcomes in every respect.

So talk to me just briefly about that. I know you do not have much time thanks to me being at the end here. But how can we ensure we can get a good, flexible plan to cover those people and even a better way than they are currently getting under Medicaid expansion?

Ms. VERMA. Well, I think that, first of all, I support coverage. And I think that, you know, the individuals who are being served in Medicaid, served through the exchange, I support people having coverage for the issues that you raised. I mean, as people are facing substance abuse, opioid addiction, they are going to need coverage, and we need to address that issue.

But if we look at what the Affordable Care Act has done, and people talk about coverage—well, coverage does not necessarily translate to access to care.

You know, I was today with an Uber driver and asking him about his coverage. And he said he had gotten coverage through the exchanges, through the Affordable Care Act, but he said, "I cannot do anything with it because my deductible is $6,000. And, you know, I cannot get to the doctor. I still cannot afford it."

And so I think that that is a great story of how coverage does not necessarily translate into access. And so, you know, as we move to a different system, I think those are things that we need to keep in mind, whether that is through the Medicaid program or through another coverage vehicle. And we need to make sure that we are providing high-quality care and also providing accessible care.

Senator PORTMAN. Thank you. And we look forward to continuing that conversation. And I know I am over time, but I do think this is going to be the key issue for us in Ohio: how do we ensure in that transition that we provide that coverage?

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Ms. Verma, you have been very patient, and you very intelligently have answered these questions of my colleagues.

And the committee has received several letters in support of Ms. Verma's nomination that I ask to be added to the record, without objection.

[The letters appear in the appendix beginning on p. 57.]

The CHAIRMAN. And finally, I would ask that any written questions for the record be submitted by 5 p.m. tomorrow, February 17, 2017.

With that, we want to thank you for being here. Thank you for your answers. Thank you for your patience.

And we will adjourn this hearing. Thanks so much.

Ms. VERMA. Thank you, Senator.

The CHAIRMAN. You bet.

[Whereupon, at 12:51 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MICHAEL B. ENZI, A U.S. SENATOR FROM WYOMING

Thank you for the opportunity to say a few words, Mr. Chairman. The nominee before us today is someone who has the background, the knowledge, and skill set to be an outstanding Administrator of the Centers for Medicare and Medicaid Services.

Ms. Verma is a talented person who is eminently qualified to oversee CMS. Her experience with State Medicaid programs has given her insight into the functional side of CMS. She knows the frustrations of interacting with the agency and can see where changes could make meaningful improvements for State flexibility and in improving processes throughout CMS.

I am hopeful that, under her leadership, CMS can emerge as a place where health-care innovation can thrive and, more importantly, a government agency that does not slow down or stop innovation.

I have spoken to Ms. Verma about the challenges facing both Medicare and Medicaid in a rural and frontier State like Wyoming, and she understands the importance of not creating one-size-fits all programs that leave rural communities without access to vital health-care services.

I look forward to working with Ms. Verma in the future and am excited to see someone with her qualifications and background willing to step away from her great success in the private sector to serve her country in this capacity.

I'd like to just focus on that, because we are in the nominations business right now, and there has been a degree of rancor in the nominations process which is unfortunate. I sometimes wonder why anybody would want to put themselves through this grueling process.

We have before us a nominee who has a good life outside of Washington. She doesn't need to be subject to personal attacks or made into a symbol of partisan discord. But, she is willing to be under an extremely high level of scrutiny to do what she thinks is the right thing.

Ms. Verma is impressive; she has practical, not just theoretical, knowledge of our Federal health care programs, and I particularly appreciate what she has said about the need to focus on the outcome for patients. At the end of the day, that should be our primary objective. I look forward to working with her as CMS Administrator.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a hearing to consider the nomination of Seema Verma to head the Centers for Medicare and Medicaid Services (CMS):

Today we will consider the nomination of Seema Verma to serve as Administrator of the Centers for Medicare and Medicaid Services. Welcome, Ms. Verma, to the Finance Committee. I appreciate your willingness to lead this key agency at this crit-

ical time. I see that your family has joined you here today to lend support. I extend a warm welcome to them as well.

CMS is the world's largest health insurer, covering over one-third of the U.S. population through Medicare and Medicaid alone. It has a budget of over $1 trillion, and it processes over 1.2 billion claims a year for services provided to some of our Nation's most vulnerable citizens.

Ms. Verma, having dealt with CMS extensively in your capacity as a consultant to numerous State Medicaid programs, you know full well the challenges the agency deals with on daily basis.

I suspect you also know that the job you've been nominated for is a thankless one, fraught with numerous challenges.

The good news is that there are opportunities in those challenges, and I believe you are the right person for the job and that you will make the most of those opportunities to improve our health-care system.

The failings of Obamacare are urgent and must be addressed in short order.

Over the past 6 years, we have watched as the system created under Obamacare has led to increased costs, higher taxes, fewer choices, reduced competition, and more strains on our economy.

Under Obamacare, health insurance premiums are up by an average of 25 percent this year alone.

Under Obamacare, Americans, including millions of middle-class Americans, have been hit with $1 trillion in new taxes.

And, under Obamacare, major insurers are no longer offering coverage on exchanges, and earlier this week, we learned that another major carrier will exit the market in 2018.

As Congress works to change course with regard to our ailing health-care system, CMS will play a major role in determining our success. I applaud the step the agency took yesterday under the leadership of HHS Secretary Price with its proposed rule to help stabilize the individual insurance markets, but there is much more work to be done and I am confident that, if you are confirmed, you will be a valuable voice in driving change.

I'd like to talk specifically about Medicaid for a moment.

The Medicaid program was designed to be a safety net for the most vulnerable Americans. As such, I understand and value the moral and social responsibilities the Federal Government has in ensuring health-care coverage for our most needy citizens. I am committed to working with States and other stakeholders, and the American public to improve the quality and ensure the longevity of the Medicaid program.

But we must also acknowledge that the Medicaid program is three times larger—both in terms of enrollment and expenditures—than it was just 20 years ago. Additionally, the Medicaid expansion under Obamacare exacerbated pressures on the program at a time when many States were already facing difficult choices about which benefits and populations to serve. As a result, we have a responsibility to consider alternative funding arrangements that could help to preserve this important program.

We also need to consider various reform proposals that can improve the way Medicaid operates. Ms. Verma, we will need your assistance in both of these efforts, and your experience in this particular area should serve you well.

On the subject of Ms. Verma's experience, I want to note for the committee that she has been credited as the creative force behind the Healthy Indiana Plan, the State's Medicaid alternative. This program provides access and quality health care to its enrollees, while ensuring that they are engaged in their care decisions. The program continues to evolve while hitting key metrics and, overall, enrollees are very satisfied with their experience.

While we may hear criticisms of this program from the other side of the dais here today, we should note that HHS and CMS leaders under the Obama administration repeatedly approved the waiver necessary to make this program a reality.

Ms. Verma has assisted a number of other State Medicaid programs as well. Her efforts all have the same focus—getting needed, high-quality care to engaged pa-

tients in a fiscally responsible way. This is exactly the mind-set we need in a CMS Administrator.

Now, Ms. Verma, as if the challenges associated with Medicaid are not enough to keep you busy as CMS Administrator, you will also be tasked with helping to ensure the longevity and solvency of the Medicare trust fund, which is projected to go bankrupt in 2028.

All told, between now and 2030, 76 million baby boomers will become eligible for Medicare. Even factoring in deaths over that period, the program will grow from approximately 47 million beneficiaries today to roughly 80 million in 2030.

Maintaining the solvency of the Medicare program while continuing to provide care to an ever expanding beneficiary base is going to require creative solutions. It will not be easy. But, we can't put it off forever, and the longer we wait, the worse it will get.

Now that I've had a chance to discuss the challenges facing CMS and some of Ms. Verma's qualifications, I want to speak more generally about recent events.

We've gone through a pretty rough patch recently on this committee, particularly as we've dealt with President Trump's nominations. I don't want to rehash the details of the past few weeks, but I will say that I hope that recent developments do not become the new normal for our committee.

As I've said before, I'm going to do all I can to restore and maintain the customs and traditions of this committee, which has always operated with assumptions of bipartisanship, comity, and good faith. With regard to considering nominations, that means a robust and fair vetting process, a rigorous discussion among committee members, and a vote in an Executive Session.

On that note, maybe the icy treatment of nominees is starting to thaw today, at least I hope it is. One tradition that has been absent here this session has been the introduction, on many occasions, of nominees by Senators of both parties from the nominees' home States, especially in cases when the nominee and the home State Senator have a relationship. I'm pleased to say that the Senior Senator from Indiana is re-affirming that tradition by appearing here today. I thank the Senator for taking the time to appear today and introduce his constituent. I'll give him a chance to do so in just a few minutes.

With that, I look forward to Ms. Verma sharing her vision and views here today. I also look forward to what I hope will be a full and fair committee process that allows us to process this nomination and report it to the full Senate in short order.

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February 15, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Hatch and Senator Wyden:

On behalf of America's Essential Hospitals and its nearly 300 member hospitals across the country, I write to support the appointment of Seema Verma, MPH, as administrator of the Centers for Medicare and Medicaid Services (CMS).

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Our members are cornerstones of care in their communities, providing primary care through trauma care, disaster response, health care workforce training, research, public health programs, and other vital services. But they do more than keep people healthy and productive—they bolster the economic health of their communities. Each year, our members generate more than $165 billion of economic activity for

their respective State economies and contribute to more than 1.25 million jobs nationally.

We believe Ms. Verma is well-qualified to lead CMS, given her deep understanding of both health-care delivery and policymaking. Through her work at essential hospitals, she has firsthand experience delivering care to low-income and other vulnerable people. She previously served as vice president of planning for the Health and Hospital Corporation of Marion County, an association member in Indiana, and as a director for the Association of State and Territorial Health Officials, in Washington, DC. In 2001, she graduated from America's Essential Hospitals' Fellows Program, which helps rising health-care leaders transform the culture of care. Also of note, Ms. Verma served as Indiana's health reform lead, a role in which she oversaw implementation of the State's Medicaid expansion waiver under then-Governor Mike Pence.

Ms. Verma will contribute an important, State-level perspective on Medicaid, insurance, health-care delivery, and public health. As States grapple with options for the future of their Medicaid program, Verma's background in innovative waivers and her proven ability to work effectively with States will engender confidence in the agency's actions.

We stand at a crossroads for health care. As CMS leads the charge for high-quality care at lower costs and with better health outcomes for all people, the agency's role and responsibilities take on heightened importance. At this critical juncture, Ms. Verma would contribute needed and valuable knowledge about Medicaid and Medicare, the complex programs on which our Nation's vulnerable people and their hospitals depend.

We look forward to working with Ms. Verma to ensure essential hospitals can sustain their commitment to those in need and to underserved communities, and to continue national efforts to foster innovation and reduce disparities in care.

We urge the committee to swiftly confirm Ms. Verma.

Sincerely,

Bruce Siegel, M.D., MPH
President and CEO

February 13, 2017

The Honorable Orrin G. Hatch
Chairman
U.S. Senate
Committee on Finance

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance

Re: Nomination of Seema Verma to be Administrator, Centers for Medicare and Medicaid Services

Dear Chairman Hatch and Ranking Member Wyden:

In previous Republican administrations, we all had the honor of leading the agency now known as the Centers for Medicare and Medicaid Services (CMS). With expenditures of $1 trillion per year and oversight over the Medicare, Medicaid, SCRIP, and now ACA programs, CMS's 5,000 employees are responsible for managing and regulating the largest health insurance program in the country. At the top of this critical agency sits the Administrator.

Regardless of how you might feel about each of these programs and the administration's policy initiatives, effective leadership of the agency is essential. Being CMS Administrator is a critical job in the executive branch, helping to assure that CMS is able to continue improving its payment capabilities, better support providers and beneficiaries, assist States, implement a wide range of broadly-supported legislative initiatives such as the major reforms in Medicare physician payments, and respond to beneficiary and Congressional requests. Having someone who understands its mission, is an expert in health policy, and has experience working with the agency is important to being a successful leader.

Seema Verma has the traits necessary to be a successful CMS Administrator. The heart and soul of the agency's work is supporting beneficiaries—seniors, low-income mothers, children or those seeking insurance through the exchanges. Seema understands that all CMS employees come to work every day with the mission of serving these diverse groups, and that the Administrator plays a critical role in supporting CMS employees in that mission.

But at the same time, to best serve beneficiaries, the policies and regulations guiding these programs must be market-based, calling upon and encouraging the best ideas of the private sector for delivering care. CMS must be a good primer to the health care sector as realized by fair and realistic regulation, to improve the quality of our country's health care while at the same time keeping tighter control of costs. Providers and patients work to get the right care at the right time, but no agency can do as much as CMS to help or hinder those efforts. Therefore the Administrator must understand the complexity and competition within the health care system, including the all-important dynamic that exists between payers and providers.

The Administrator must assure that the agency makes timely and coherent decisions in the best interests of the beneficiary and taxpayer with a focus on making health care more affordable for all. And of course, it is important to both the employees of CMS and to the public that there be a strong degree of transparency in the decisions and actions of the Administrator and her senior advisors. With trillions of dollars and the health of millions of beneficiaries at stake, taxpayers and elected officials must understand the process and rationale for CMS decisions and actions. This is particularly important for decisions related to the implementation of new legislation—and CMS has many such decisions ahead, including countless decisions to assure the effective implementation of physician payment reform and changes in the ACA.

While all of us might have our preferred policies and ideas for how CMS can improve the health care delivery system, Seema Verma has the kind of health policy leadership experience needed to carry out these essential responsibilities. Through her interactions with CMS as she negotiated Indiana's Medicaid waiver and other state reform proposals, she understands the kind of leadership and commitment needed to make the agency work well. Through her career-long commitment to improving the well-being of beneficiaries and the quality and efficiency of insurance programs, she has the heart to succeed as well.

For these reasons, most importantly for the over 100 million Americans served by CMS and for American taxpayers, we support Seema Verma's confirmation as soon as possible. We believe CMS and its critical responsibilities will be in good hands.

Sincerely,

William L. Roper
Gail R. Wilensky
Leslie V. Norwalk
Mark B. McClellan
Thomas A. Scully

February 15, 2017

The Honorable Orrin G. Hatch
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Hatch:

We write to endorse without reservation the nomination by President Donald J. Trump of Ms. Seema Verma for the position of Administrator of the Centers for Medicaid and Medicare Services. Ms. Verma has decades of experience working with State health care and industry leaders to reform and improve services for the most vulnerable in our communities.

There are few professionals in the Nation who possess the respect, hands-on experience, and relationships with State leaders that will be critical as the Congress and administration work to repeal and replace the Affordable Care Act. Medicaid represents an enormous burden on State budgets combined with an unprecedented opportunity to reform a Federal entitlement program long in need of structural

changes. Ms. Verma is the ideal candidate to oversee the reform of Medicaid design and ensuring pending State waivers are fast-tracked and with the underlying premise that Medicaid is a State-Federal partnership.

As a consultant working alongside States and industry leaders throughout the legislative process and implementation of the Affordable Care Act, Ms. Verma has a unique understanding of the nexus between the health insurance marketplace and the States and the impact of the ACA on coverage and cost.

President Trump and Vice President Pence have made an inspired choice for CMS Administrator in Ms. Seema Verma. We look forward to working with Congress and the administration to truly reform health-care delivery and insurance coverage in our great Nation.

Sincerely,

Governor Eric Holcomb Indiana	Governor Robert Bentley Alabama	Governor Douglas A. Ducey Arizona
Governor Asa Hutchinson Arkansas	Governor Nathan Deal Georgia	Governor Edward J. Baza Calvo Guam
Governor Sam Brownback Kansas	Governor Matt Bevin Kentucky	Governor Paul R. LePage Maine
Governor Rick Snyder Michigan	Governor Phil Bryant Mississippi	Governor Eric R. Greitens Missouri
Governor Chris Christie New Jersey	Governor Doug Burgum North Dakota	Governor John R. Kasich Ohio
Governor Mary Fallin Oklahoma	Governor Dennis Daugaard South Dakota	Governor Bill Haslam Tennessee
Governor Greg Abbott Texas	Governor Gary R. Herbert Utah	Governor Scott Walker Wisconsin

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FEBRUARY 15, 2017

The Honorable Orrin G. Hatch
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20515

Dear Chairman Hatch:

I want to personally reach out to you and offer my unequivocal endorsement of Ms. Seema Verma who was nominated by President Donald J. Trump to serve in the position of Administrator of the Centers for Medicaid and Medicare Services (CMS). As Governor of Kentucky, I look for three key attributes when making appointments to my cabinets—character, competence, and commitment. Ms. Verma will unquestionably bring these positive characteristics and much more to the position.

Ms. Verma is well positioned and uniquely qualified to serve in her role. As you are aware, the administration of the Medicaid program is a partnership between the State and the Federal Government—specifically, CMS; however, in recent years, it has not felt this way. The Affordable Care Act (ACA) was forced upon Americans with minimal input from States or the public. CMS, under the former administration, gave very little flexibility to States to be innovative or tailor Medicaid pro-

grams to fit the needs of their unique populations or obtain relief from the burdens of the ACA. During this time, Ms. Verma successfully navigated mountains of regulation to guide States through the frustrating process of getting permission to enact innovative policies. Ms. Verma is ideally suited to eliminate unnecessary red tape and to grant much needed flexibility to States to develop solutions for their populations.

In fact, I can speak to this first hand as I was fortunate enough to work with Ms. Verma in the development of Kentucky HEALTH, an innovative section 1115 waiver designed to improve health outcomes and create fiscal sustainability for Kentucky's Medicaid program. Ms. Verma's deep understanding of the Medicaid program and her experience navigating CMS, was invaluable as we made policy decisions in crafting our waiver. This understanding and experience will be especially valuable to the Trump administration and Congress as much needed changes to America's health system are considered.

Additionally, I am especially appreciative of her understanding of Medicaid from the State's perspective. Such perspective is critical as policies and regulations are crafted that will impact how States administer the Medicaid program.

For these reasons, and many more, I enthusiastically encourage the Senate to confirm the appointment of Ms. Seema Verma. Kentucky looks forward to working with Congress, President Trump, Vice President Pence, and the new leadership at the U.S. Department of Health and Human Services on much-needed and meaningful healthcare reform.

Sincerely,

Matthew G. Bevin
Governor of Kentucky

PARTNERSHIP FOR QUALITY HOME HEALTHCARE

February 15, 2017

The Honorable Orrin G. Hatch
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the Partnership for Quality Home Healthcare (Partnership), we are writing in strong support of the nomination of Seema Verma to serve as Administrator of the Centers for Medicare and Medicaid Services (CMS).

As the nation's premier association of leading skilled home health agencies, the Partnership is committed to delivering high quality health-care services in the home, offering value to taxpayers and to families. Our nurses, therapists and caregivers provide essential skilled care services in an increasingly complex regulatory environment that is unnecessarily duplicative, burdensome and challenging.

The Partnership supports Ms. Verma's nomination because of her extensive experience in the private sector health-care field, which we believe contributes to her understanding of the complexity of delivering care in such a highly regulated and tightly controlled environment. The Partnership is eager to work with Ms. Verma on common-sense solutions to reduce regulatory burden and make Medicare's home health benefit more accessible to seniors in need. We also believe that it is critical that the largest health-care payer in the Nation have a confirmed, permanent Administrator.

Accordingly, we enthusiastically support Ms. Verma's nomination and urge her expeditious confirmation.

Very Truly Yours,

Colin Roskey
Executive Vice President

LETTER SUBMITTED BY HON. DEAN HELLER, A U.S. SENATOR FROM NEVADA

Nevada Legislature

January 10, 2017

The Honorable Dean Heller
324 Hart Senate Office Building
Washington, DC 20510

Dear Senator Heller:

We are writing to express our concern regarding plans to repeal the Affordable Care Act. Specifically, we are concerned that Republicans in Congress are pushing ahead with a repeal of the Affordable Care Act despite having no viable replacement legislation ready to enact.

Failure to immediately enact replacement legislation risks creating uncertainty in the insurance marketplace. Such uncertainty will likely result in higher out-of-pocket costs and fewer insurance options for Nevada's families while simultaneously placing an increased burden on our State budget.

As you are aware, Governor Sandoval worked closely with the Legislature and ultimately signed legislation creating the Silver State Health Exchange in 2011. Subsequently, more than 300,000 Nevadans have gained access to health-care coverage, either by purchasing it on the exchange or by meeting the expanded Medicaid eligibility requirements.

In light of these facts, we hope that you will address the following questions regarding the planned repeal of the Affordable Care Act:

1. What steps do you plan to take to ensure that the more than 88,000 Nevadans who have purchased health insurance through the Silver State Health Exchange continue to have the ability to purchase health insurance with adequate coverage in a transparent marketplace?
2. What steps do you plan to take to ensure that the more than 77,000 Nevadans who are eligible for Federal tax credits under the Affordable Care Act to help purchase private insurance will continue to have access to affordable health insurance options with adequate coverage?
3. What steps do you plan to take to ensure that the 217,000 Nevadans who are receiving health care under the Medicaid expansion remain covered?
4. The Affordable Care Act guarantees coverage vital to preventative services for women, including cancer screenings and birth control. What steps do you plan to take to ensure that the Affordable Care Act's coverage guarantees remain intact for women's health?
5. The Affordable Care Act guarantees that Nevadans with pre-existing conditions will not be denied health care and ends lifetime minimums on coverage. It also allows younger people, many of whom are saddled with college debt and cannot afford insurance, to stay on their parents' insurance until they are 26. What steps do you plan to take to preserve those coverage guarantees?

The lack of clarity regarding viable alternatives to the Affordable Care Act from the incoming administration and Republican congressional leadership is troubling. While Congress has expended considerable time and energy over the past several years talking about the law, hundreds of thousands of Nevadans have relied in good faith on the Affordable Care Act to obtain health insurance. Repealing the law without implementing an adequate replacement will put those Nevadans' health and well-being at risk.

Further, any congressional action that creates a large gap in insurance coverage will likely result in more Nevadans relying on State-funded social service programs. Most of these programs are already under resourced. Nevada cannot afford to shoul-

der this new financial burden created by politicians in Washington failing to live up to guarantees that the Federal Government previously made to our citizens.

We hope you will use your position as Nevada's senior United States Senator and a member of the majority party to protect the thousands of Nevada families who are now at risk of losing their health insurance. We also hope you will take steps to ensure that our State does not bear any unfair and unnecessary costs of caring for people who stand to lose that coverage in the near future.

We look forward to your prompt reply.

Sincerely,

Aaron D. Ford
Majority Leader
Nevada State Senate

Jason Frierson
Speaker
Nevada State Assembly

PREPARED STATEMENT OF SEEMA VERMA, NOMINATED TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, members of the committee, thank you for allowing me to appear before you today. I am deeply honored to be here, and am grateful for your consideration of my nomination by President Trump to be Administrator of the Centers for Medicare and Medicaid Services. I appreciate the time many of you and your staffs have taken to meet with me in advance of this hearing.

Before I begin my statement, I would like to take a moment to introduce my family. I am truly grateful for the love and support of my parents Mr. and Mrs. Verma, my husband Sanjay Mishra and my two children Maya and Shaan.

I have often been asked, by my family as well as by the members of this committee, why I would be interested in a job as complex and difficult as running a trillion dollar government agency such as CMS.

I humbly accepted President Trump's call to service because I understand what is at stake. I have never stood on the sidelines of our Nation's health-care debate, merely pointing out what is wrong with our health-care system. I have spent my entire life helping the most disadvantaged in our society receive the kind of accessible, affordable and competent health-care service that our country's health-care system is renowned for.

More than 20 years ago, when I graduated from college, I started my career working on national policy on behalf of people with HIV and AIDS, as well as low-income mothers to improve birth outcomes. I fought for coverage, for greater health-care access and for improving the quality of care—and have continued to fight for these issues for the past 20 years.

But, sadly, I am deeply concerned about our health-care system. There is frustration all around. Doctors are increasingly frustrated by a number of costly and time-consuming burdens, and quite frankly, many Americans are not getting the care that they need.

We have a long way to go in improving health outcomes. Health care continues to grow more and more expensive, and the American people are tired of partisan politics. They just want their health-care system fixed.

And I know this, not simply because I have worked in health care, but because of how intimately it has affected my personal life.

Two people I truly love have been immensely affected by enormous health-care challenges.

My own mother is a breast cancer survivor due to early diagnosis and treatment, and I thank God that she is with me today.

Also, a few years back, my neighbor was diagnosed with a stage 4 neuroblastoma. A large tumor had been growing for some time, wrapping around his kidney. Aidan went through excruciating chemotherapy, radiation, stem cell treatment, surgeries, and countless trips to the hospitals and doctors. Experimental treatments were used by his medical team. This treatment regimen would be excruciating for anyone to endure, but Aidan was only 4 years old. At such a young age, we didn't know if he would live or die.

But this May Aidan will celebrate his 12th birthday.

Both my mom and Aidan are testaments to the ingenuity of the American medical system that saved their lives, as well as to the grace of God. This is why people travel from around the world to get care here in the United States.

I want to be part of the solution making the system work for all Americans. I want to be able to look my children in the eye and tell them I did my part to serve my country and make things better for people who often do not have a voice. I want to tell my children that I fought to ensure that all American families, like Aidan's and my own, have the care that they need.

This is a formidable challenge, but I am no stranger to achieving success under difficult circumstances.

My father left his entire family to immigrate to the United States during the 1960s to pursue four degrees while he worked to earn money to pay for school, as well as to provide for his family.

On my mother's side, my grandmother was married at the age of 17 with no more than a 5th-grade education, but my mother was the first woman in her family to finish a master's degree.

My parents made a lot of sacrifices along the way to provide me with opportunities they didn't have.

I am extremely humbled as a first-generation American to be sitting before this committee after being nominated by the President of the United States. It is a testament to the fact that the American Dream is very much alive for those willing to work for it.

And it is my passion to continue to work on the front lines of health care, changing and improving this country's health care delivery system.

Throughout my career, I have brought people together from all sides of the political spectrum to forge solutions that worked for everyone. These consensus efforts have resulted in programs that have provided health-care coverage to over a million vulnerable Americans. One of the proudest moments of my career was watching the Indiana legislature pass the Healthy Indiana Plan with a bipartisan vote.

For me, today's hearing is not simply a matter of finding a good executive to run a large government bureaucracy. It is about bringing someone to the table who fundamentally understands that the future of our country's health care is at stake.

CMS is a $1 trillion agency, and through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace, it covers over 100 million people, many of whom are among our most vulnerable citizens. Providing high quality, accessible health care for these Americans isn't just a luxury, it's a necessity and often a matter of life and death.

Should I be confirmed, I will work to ensure that CMS's programs are focused on achieving positive outcomes. As the Nation's largest purchaser of health care, we must do more, achieve more than the mere distribution of insurance cards. We can use these programs to truly make a difference in people's lives to prevent and cure disease, manage chronic illnesses, and promote healthy lifestyles and independence from government assistance.

In order to achieve our goals, I will work toward policies that foster patient-centered care and increase competition, quality, and access while driving down costs.

Patients and their doctors should be making decisions about their health care, not the Federal Government. We need to ensure that people have choices about their care. We shouldn't assume that all vulnerable or low income populations don't want choices or aren't capable of making the best decisions for themselves and their families. We must find creative ways to empower people to take ownership of their health and be engaged in making cost and quality decisions as they seek care. CMS's rules and regulations shouldn't drive doctors and providers away or crowd out care, but should instead support them in delivering high quality care to their patients.

If confirmed, I will work toward modernizing CMS's programs to address the changing needs of the people they serve, leveraging innovation and technology to drive coordinated, cost effective care. I will ensure that efforts around preventing fraud and abuse are a priority, since we cannot afford to waste a single taxpayer

dollar. Ultimately, while we strive to provide the highest level of care to our current beneficiaries, we must solidify the programs' sustainability for future generations.

I will work toward ushering in a new era of State flexibility and leadership. For too long our State partners have been sharing in the cost but have not been allowed to have a meaningful role in decision making. We need to guarantee that appropriate protections are in the place for our most vulnerable populations and hold States accountable for achieving outcomes around quality and access, but we also need to create an environment that incentivizes innovation over paper-pushing, so that we can find new and better ways of achieving our mutual goals.

If I have the honor of being confirmed, I will carry this vision, along with my strong belief in open communication, collaboration, and bipartisanship with me to CMS. I will work with you, be responsive to your inquiries and concerns, and value your counsel.

I will do everything I can to ensure that your constituents are being properly served by the programs at CMS, and that these programs operate in an efficient and transparent manner.

I thank you for your consideration of my nomination.

SENATE FINANCE COMMITTEE

STATEMENT OF INFORMATION REQUESTED OF NOMINEE

A. BIOGRAPHICAL INFORMATION

1. Name (include any former names used): Seema Verma.
2. Position to which nominated: Administrator, Centers for Medicare and Medicaid Services.
3. Date of nomination: January 20, 2017
4. Address (list current residence, office, and mailing addresses):
5. Date and place of birth: September 27, 1970, Portsmouth, Virginia.
6. Marital status (include maiden name of wife or husband's name):
7. Names and ages of children:
8. Education (list secondary and higher education institutions, dates attended, degree received, and date degree granted): Johns Hopkins School of Hygiene and Public Health, Baltimore, MD, Master of Public Health—Health Policy and Management, 1996; University of Maryland, College Park 1988–1993, Bachelor of Science, Life Sciences, 1993.
9. Employment record (list all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment): Founder, president, and CEO, SVC Inc., Indianapolis, IN (2001–present); vice president, corporate planning, Health and Hospital Corporation, Indianapolis, IN (1999–2001); Director of Program Development/Healthy Babies Initiative, Marion County Health Department, Indianapolis, IN (1997–1999); Project Director HIV/AIDS and Consultant, Association of State and Territorial Health Officials (ASTHO), Washington DC (1993–1997).
10. Government experience (list any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments, other than those listed above): As stated in Item 9 above, from 1997–1999, I was employed by the Marion County Health Department. Attachment 1 includes a list of consulting projects in which I have engaged on behalf of various State government agencies through prime contracts or subcontracts awarded to SVC, Inc.
11. Business relationships (list all positions held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, other business enterprise, or educational or other insti-

tution): Owner, president, and CEO of SVC, Inc. Please also refer to Attachment 1 for consulting projects in which I have engaged through SVC.

12. Memberships (list all memberships and offices held in professional, fraternal, scholarly, civic, business, charitable, and other organizations): I no longer hold positions with any such organizations. In 2016 I held the following positions with these organizations, from which I recently resigned: board member, Aidan Brown Foundation; chair of the International Festival, Teacher Luncheon's, Sycamore School.

13. Political affiliations and activities:

    a. List all public offices for which you have been a candidate.

    N/A.

    b. List all memberships and offices held in and services rendered to all political parties or election committees during the last 10 years.

    N/A.

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

Individual Contributions

Recipient	Amount	Date of Contribution
Mitch for Governor Campaign Committee	$1,001	March 21, 2007
Mitch for Governor Campaign Committee	$1,001	March 21, 2007
Mitch for Governor Campaign Committee	$1,000	June 10, 2008
Eric Holcomb for Indiana	$300	June 10, 2015
Friends of Susan Brooks	$1,000	November 16, 2015
Eric Holcomb for Indiana	$351	January 27, 2016
Erin Houchin for Congress	$750	March 31, 2016
Friends of Susan Brooks	$250	October 12, 2016
Friends of Todd Young	$500	October 18, 2016

SVC, Inc. Contributions

Recipient	Amount	Date of Contribution
Aiming Higher	$5,000	May 16, 2012
Mike Pence for Indiana	$500	June 12, 2012
Turner for State Representative	$500	June 13, 2012
Turner for State Representative	$300	December 20, 2013
Eric Holcomb for Indiana	$200	October 5, 2016

14. Honors and awards (list all scholarships, fellowships, honorary degrees, honorary society memberships, military medals, and any other special recognitions for outstanding service or achievement): Sagamore of the Wabash, an Indiana honorary award given to me by Vice President and former Governor of Indiana Mike Pence.

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

"Election Headlines Bury Need for a Discussion on Future of Health Care," *The Hill,* and *Real Clear Health,* October 22, 2016.

"Healthy Indiana 2.0 Is Challenging Medicaid Norms," *Health Affairs,* August 29, 2016.

"IN: Health Care Reform Amidst Colliding Values," *Health Affairs,* May 1, 2008.

16. Speeches (list all formal speeches you have delivered during the past 5 years which are on topics relevant to the position for which you have been nominated):

Testimony, Energy and Commerce Health Committee, June 12, 2013 (attached at Attachment 2).

I have given numerous speeches on the Affordable Care Act and Medicaid Reform. There are no formal transcripts, but PowerPoint presentations were previously provided.

- Lily Speakers Bureau
- America's Health Insurance Plans
- National Association of State Health Policy
- IU Life Sciences Collaborative
- Docs4Patient Care
- Civic Federation
- AHEC
- A-TriAcc
- Republican Governor's Association
- National Governor's Association
- Ascension Health Care Conference
- Energy and Commerce Medicaid Task Force

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

For over 20 years I have worked with government health-care programs on the Federal, State, and local level, and I started my own health-care consulting company 15 years ago. In this capacity, I have worked with a variety of health-care organizations on a range of issues from public health, insurance, and Medicaid giving me broad-based health-care expertise.

I have spent my career working in the health-care sector trying to improve access to quality health-care services for vulnerable populations, including those with HIV/AIDS and pregnant women and their babies. More recently, I have worked extensively with Governors' offices across the Nation to develop market-driven approaches that empower individuals to engage in improving their health to achieve better health outcomes.

I developed Governor Daniels's Healthy Indiana Plan and was named his Health Care Reform Lead. In this role, I was responsible for Indiana's response to the Affordable Care Act, across all State agencies. In addition, I advised Governor Pence on health-care issues. Following the election, I was asked to design and implement his signature health plan, the Healthy Indiana Plan 2.0. I supported negotiations with the Health and Human Services Agency (HHS) and coordinated the agency's successful implementation plan, execution, and launch of the program. In addition, I have worked with Governors Bevin, Branstad, Haslam, and Otter to develop their health-care programs, and was also involved in crafting Ohio's Medicaid waiver.

Over the last 6 years, I have worked with a variety of State governments and other organizations to implement the Affordable Care Act, both on the Medicaid and insurance sides. I have developed a working knowledge of thousands of pages of regulations and have been on the front lines of implementation.

The Medicare program is a critical and important program. I will bring my strong knowledge of health insurance and delivery of health-care services to ensuring high quality health care for American's seniors.

It would be an honor to serve my country as the Centers for Medicare and Medicaid Services Administrator, and I look forward to the opportunity.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, associations, or organizations if you are confirmed by the Senate? If not, provide details.

   Yes.

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

   No.

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

   No.

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

   Yes.

C. POTENTIAL CONFLICTS OF INTEREST

1. Indicate any investments, obligations, liabilities, or other relationships which could involve potential conflicts of interest in the position to which you have been nominated.

   In consultation with the ethics officials of the Department of Health and Human Services and the Office of Government Ethics, I have identified certain investments that I will divest to avoid potential conflicts of interest. In addition, I will recuse myself from matters involving my former employer, SVC, Inc. and a number of its consulting clients, and I am arranging for the purchase of SVC, which I plan to sell if confirmed by the Senate; and I also will recuse myself from issues that may pose a conflict with my husband's psychiatric medical practice.

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

   As stated in my response to Item C.1, I have consulted with the ethics officials of the Department of Health and Human Services and the Office of Government Ethics to identify potential conflicts of interest, and have agreed to address those conflicts in an Ethics Agreement, attached as Attachment 3.

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

   I worked on the passage of the Healthy Indiana Plan and amendments to the law in the State of Indiana, as an advisor to the State/Governor's offices.

4. Explain how you will resolve any potential conflict of interest, including any that may be disclosed by your responses to the above items. (Provide the committee with two copies of any trust or other agreements.)

   As stated in my responses to Items C.1 and C.2, above, I have consulted with the ethics officials of the Department of Health and Human Services and the Office of Government Ethics to identify potential conflicts of interest, and have agreed to address those conflicts in an Ethics Agreement. In the course of performing my duties, I will abide by any recommendations made to me by agency ethics officials.

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

   My Ethics Agreement is included as Attachment 3.

D. LEGAL AND OTHER MATTERS

1. Have you ever been the subject of a complaint or been investigated, disciplined, or otherwise cited for a breach of ethics for unprofessional conduct before any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, provide details.

   No.

2. Have you ever been investigated, arrested, charged, or held by any Federal, State, or other law enforcement authority for a violation of any Federal, State, county, or municipal law, regulation, or ordinance, other than a minor traffic offense? If so, provide details.

   No.

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

   No.

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

   No.

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

   None.

E. TESTIFYING BEFORE CONGRESS

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

   Yes.

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

   Yes.

Attachment 1

Below are two charts setting forth information about consulting work done by SVC, Inc. The first chart shows direct contracts, and the second chart shows subcontracts.

Direct Contracts

State or Entity	Agency	Period
Indiana	Family Social Services Association, Indiana State Department of Health	2002–Present
Virginia	Department of Health, OMPP	2015–2016
Nebraska	Department of Insurance	2012–2013
Tennessee	Health Care Finance and Administration	2014–2015
Maine	Department of Health and Human Services	2012–2013
Richard M. Fairbanks Foundation		2015–Present
First Data		2013–2014

Direct Contracts—Continued

State or Entity	Agency	Period
Lilly USA		2013
Eli Lilly and Company		2013–2014
Health Management Associates		2009–2012
IN Hemophilia and Thrombosis		2015
Indiana State Medical Association		2014
HSA Coalition		2014–2016
Indiana Hand to Shoulder Surgery Associates		2014–2015
National AHEC Organization		2014
Maximus		2016–Present
Roche Diagnostics		2010–2012
Indiana Dental Association		2012

Subcontracts

Prime Contractor	State or Entity	Agency	Period
Milliman Actuaries	Iowa	Department of Human Services	2013–Present
Milliman Actuaries	South Carolina	Department of Health and Human Services	2012–Present
Milliman Actuaries	Ohio	Department of Medicaid	2015–Present
Milliman Actuaries	Michigan	Department of Community Benefit	2013–2014
Milliman Actuaries	Jefferson County, AL		2014–2015
Hewlett Packard Enterprises	Indiana	FSSA	2008–Present
Hewlett Packard Enterprises	Arkansas	Department of Human Services	2015–Present
Hewlett Packard Enterprises	Kentucky	Cabinet of Health and Family Services	2016–Present
Boise State University	Idaho	Department of Health and Welfare	2013
Health Management Associates	Indiana	FSSA and Lawrence County Community Health and Wellness Center	2006–2011
High Point Global	Federal Government	CMS	2016–Present

Attachment 2

The Need for Medicaid Reform: A State Perspective

Testimony Presented by Seema Verma
SVC, Inc.
June 12, 2013

Summary

Medicaid has undoubtedly played a considerable role in the lives of many, providing access to health care for our Nation's most vulnerable populations. There is no question it has helped many of its participants. However, designed in 1965, the program has not kept pace with the modern health-care market. Its rigid, complex rules designed to protect enrollees have created an intractable program that does not foster efficiency, quality, or personal responsibility for improvement in health status. Escalating State costs have not translated into quality or consistent outcomes.

Failure to reform the program will jeopardize States' ability to care for those Medicaid was envisioned to serve, including low-income children, pregnant women, and the aged, blind, and disabled. While the program is jointly funded by the State and Federal Government, it is not jointly managed. States are largely dependent on Federal policy, regulation, and permission to operate their programs. Administrative review and approval processes add layers of administrative bureaucracy to the program that thwart States' ability to innovate.

Notwithstanding the cumbersome regulatory review process, there are many examples of State innovation that have emerged. To transform Medicaid, States must be given the flexibility and opportunity to innovate without these undue Federal constraints. Reform efforts should center, at minimum, around encouraging consumer participation in health care, holding States accountable based on quality outcomes versus compliance with bureaucratic requirements, encouraging flexible managed care approaches, and allowing States to use flexible funding mechanisms.

INTRODUCTION

Good morning, members of the committee. My name is Seema Verma. I am the president of SVC, Inc., a policy consulting company, and in this role have been advising Governor offices, State Medicaid programs, and State Departments of Health and Insurance. I have worked in a variety of States including Indiana, South Carolina, Maine, Nebraska, Iowa, and Idaho. I am also the architect of former Indiana Governor Mitch Daniels's Healthy Indiana Plan, the Nation's first consumer-directed health plan for Medicaid beneficiaries.

OVERVIEW

Designed in 1965 for our most vulnerable populations, the Medicaid program has not kept pace with the modern health-care market. Its rigid, complex rules designed to protect enrollees have also created an intractable program that does not foster efficiency, quality, or personal responsibility. The impact of these issues is more pronounced as States are entrenched in the fierce debate around Medicaid expansion. Reluctance to expand is not indifference to the plight of the uninsured, but trepidation for the fiscal sustainability of the program and knowledge that expanding without reform will have serious consequences on Medicaid's core mission to serve the neediest of Americans.

INCREASING COSTS OF MEDICAID AND STATE BUDGETS

Medicaid comprises nearly 24%[1] of State budgets, and its costs are growing.[2] This is due to enrollment growth, population demographics, and Federal requirements. The aging baby boomer population will soon require expensive long-term care. The Affordable Care Act (ACA) requires maintenance of effort and implementation of hospital presumptive eligibility, Modified Adjusted Gross Income which eliminates asset tests for the non-disabled, and the ACA insurer tax will cost States an esti-

[1] National Governors Association and National Association of State Budget Officers (2012). The Fiscal Survey of States. Retrieved online: *http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey.pdf.*

[2] Deloitte (2010). Issue Brief: Medicaid Long-Term Care: The Ticking Time Bomb. Retrieved online: *http://www.deloitte.com/assets/Dcom-UnitedStates/local%20Assets/Documents/US_CHS_2010LTCinMedicaid_062210.pdf.*

mated $13 to $14.9 billion.[3] Additionally, there is the clawback provision burden where States have an unprecedented requirement to finance the Medicare program.

ACCESS AND QUALITY

Despite growing outlays of public funds, a Medicaid card does not guarantee access or quality of care. In a survey of primary care providers, only 31% indicated willingness to accept new Medicaid patients.[4] In 2012, 45 States froze or reduced provider reimbursement rates,[5] Medicaid access issues are tied to under-compensation of providers; on average Medicaid payments are 66% of Medicare rates,[6] and many providers lose money seeing Medicaid patients. Medicaid beneficiaries struggle to schedule appointments, face longer wait times, and have difficulty obtaining specialty care.[7] These access challenges will be more pronounced as Medicaid recipients compete with the tens of millions of newly insured under the ACA. Studies also show Medicaid coverage does not generate significant improvements in health outcomes,[8] decrease emergency room (ER) visits or hospital admissions,[9] and participants have higher ER utilization rates than other insured populations.

STATE CONSTRAINTS

At Medicaid's core is a flawed structure. While jointly funded, by the Federal and State governments, it is not jointly managed. States are burdened by Federal policy and endure lengthy permission processes to make routine changes. Notwithstanding the cumbersome procedure, 1115 waivers provide a pathway for State innovation. However, the approval route is so daunting that States often abandon promising ideas if a waiver is necessary. Absent are evaluation guidelines, required timelines, and there is a capricious nature to the approvals, as waivers do not transfer from one State to another. Even with positive outcomes, a new administration has the authority to terminate a waiver.

Despite intense Federal oversight, results vary substantially, and there are no incentives for States to achieve quality outcomes. For example, the average cost to cover an aged Medicaid enrollee is $5,247 in New Mexico versus $24,761 in Connecticut,[10] and annual growth rates also very.[11] Replacing oversight of day-to-day administrative processes, the Federal and State governments should collaborate to identify program standards and incentives. States should be provided with flexibility to achieve these goals, and successful States should be rewarded with reduced oversight.

Medicaid's uncompromising cost-sharing policies are illustrative of a key failure. These regulations disempower individuals from taking responsibility for their health, allow utilization of services without regard for the public cost, and foster dependency. While some policies may be appropriate for certain populations, in an era of expansion to non-disabled adults, they must be revisited. Revised cost-sharing policies should consider value-based benefit design and incent enrollees to evaluate cost, quality, and adopt positive health behaviors. Indiana's Healthy Indiana Plan (HIP) waiver applied principles of consumerism with remarkable results; lowering inappropriate ER use and increasing prevention.

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[3] Milliman (2012). PPACA Health Insurer Fee Estimated Impact on State Medicaid Programs and Medicaid Health Plans. Retrieved online: *http://publications.milliman.com/publications/health-published/pdfs/ppaca-health-insurer-fee.pdf.*

[4] Decker, S. (2012). In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs,* 31(8), 1673–79. Retrieved online: *http://content.healthaffairs.org/content/31/8/1673.abstract.*

[5] The Henry J. Kaiser Family Foundation (2012). Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment, and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013. Retrieved online: *http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8380.pdf.*

[6] Kaiser Family Foundation. Medicaid-to-Medicare Fee Index. Retrieved online: *http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.*

[7] Bisgaier, J., and Rhodes, K. (2011). Auditing Access to Specialty Care for Children with Public Insurance. *The New England Journal of Medicine,* 324(24), 2324–33. Retrieved online: *http://www.nejm.org/doi/pdf/10.1056/NEJMsa1013285.*

[8] Baicker, K., Taubman, S., Allen, H., Bernstein, M., Gruber, J., Newhouse, J., Schnelder, E., Wright, B., Zaslavsky, A., and Finkelstein, A. (2013). The Oregon Experiment—Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine,* 368, 1712–22. Retrieved online: *http://www.nejm.org/doi/full/10.1056/NEJMsa1212321#t=abstract.*

[9] *Ibid.*

[10] Based on Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS–64 reports. Retrieved online: *http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee-fy2009/.*

[11] Based on Urban Institute estimates from CMS Form 64. Retrieved online: *http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending-fy90-fy10/.*

CONCLUSION

Congress should reform Medicaid to assure long-term fiscal sustainability and access to quality services that improve the health of enrollees. A fundamental paradigm shift in management is required, and the program should be reengineered away from compliance with bureaucratic policies that do not change results to aligning incentives for States, providers, and recipients to improve outcomes. States are best positioned to develop policies that reflect the local values of the people they serve and should be given the flexibility to do so.

Attachment 3

January 31, 2017

Ms. Elizabeth Fischmann
Associate General Counsel for Ethics
Designated Agency Ethics Official
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 710–E
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Fischmann:

The purpose of this letter is to describe the steps that I will take to avoid any actual or apparent conflict of interest in the event that I am confirmed for the position of Administrator, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services.

As required by 18 U.S.C.§ 208(a), I will not participate personally and substantially in any particular matter in which I know that I have a financial interest directly and predictably affected by the matter, or in which I know that a person whose interests are imputed to me has a financial interest directly and predictably affected by the matter, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). I understand that the interests of the following persons are imputed to me: any spouse or minor child of mine; any general partner of a partnership in which I am a limited or general partner; any organization in which I serve as officer, director, trustee, general partner, or employee; and any person or organization with which I am negotiating or have an arrangement concerning prospective employment.

Upon confirmation, I will resign from my position with SVC, Inc. I will divest my financial interest in SVC, Inc. within 90 days of my confirmation. I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of this entity until I have divested it, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). During my appointment as Administrator, I will not provide any services to SVC, Inc., except to the extent that I may need to comply with any requirements involving legal filings, taxes, fees, or similar matters relating to divesting my financial interests in SVC, Inc. or winding it down. For a period of 1 year after I divest my financial interest in SVC, Inc., I will not participate personally and substantially in any particular matter involving specific parties in which I know SVC, Inc. or the purchaser of SVC, Inc. is a party or represents a party, unless I am first authorized to participate, pursuant to 5 CFR § 2635.502(d). In addition, I will not participate personally and substantially in any particular matter involving specific parties in which I know a former client of mine is a party or represents a party, for a period of 1 year after I last provided service to that client, unless I am first authorized to participate, pursuant to 5 CFR § 2635.502(d). Until I have received full payment from the purchaser for the sale of SVC, Inc., I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the ability or willingness of the purchaser to make full payment to me, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1).

I provided consulting services to the States of Arkansas, Indiana, Iowa, Kentucky, Ohio, South Carolina, and Virginia through SVC, Inc. Pursuant to 5 CFR § 2635.502(d), I will seek a written authorization to participate personally and substantially in particular matters involving specific parties in which I know the States

of Arkansas, Indiana, Iowa, Kentucky, Ohio, South Carolina, and Virginia are a party or represent a party.

Additionally, following my appointment, my spouse and I will divest our interests in the following entities within 90 days of my confirmation:

Alphabet Inc. Class A
Alphabet Inc. Class C
Biogen Inc.
Columbia Seligman Communications and Information Fund
Credit Suisse SPSIOP Index Market Linked Note (MLZKV)
Exxon Mobile Corp.
Fidelity Canada Fund
General Electric
Halliburton Company
International Business Machines Corp.
Johnson and Johnson
McDonalds Corp.
Merck and Company, Inc.
Oracle Corp.
Procter and Gamble Co.
Schlumberger Limited
Spectra Energy Corp.
Travelers Companies Inc.
Unilever PLC New ADR
Vanguard Energy Fund

With regard to each of these entities, I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the entity until I have divested it, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

I understand that I may be eligible to request a Certificate of Divestiture for qualifying assets and that a Certificate of Divestiture is effective only if obtained prior to divestiture. Regardless of whether I receive a Certificate of Divestiture, I will ensure that all divestitures discussed in this agreement occur within the agreed-upon time frames and that all proceeds are invested in non-conflicting assets.

My spouse practices medicine as a psychiatrist with the Indiana Health Group, Indianapolis, IN. Additionally, he holds a financial interest in the Indiana Health Group. As Administrator, I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1).

In order to avoid potential conflicts of interest during my appointment as Administrator, I, my spouse, or any minor children of mine will not acquire any direct financial interest in entities listed on the FDA prohibited holdings list or in entities involved, directly or through subsidiaries, in the following industries: (1) research, development, manufacture, distribution, or sale of pharmaceutical, biotechnology, or medical devices, equipment, preparations, treatment, or products; (2) veterinary products; (3) health-care management or delivery; (4) health, disability, or workers compensation insurance or related services; (5) food and/or beverage production, processing, or distribution; (6) communications media; (7) computer hardware, computer software, and related Internet technologies; (8) wireless communications; (9) social sciences and economic research organizations; (10) energy or utilities; (11) commercial airlines, railroads, shiplines, and cargo carriers; or (12) sector mutual funds that concentrate their portfolios on one country other than the United States. In addition, we will not acquire any interests in sector mutual funds that concentrate in any of these sectors.

I have been advised that this ethics agreement will be posted publicly, consistent with 5 U.S.C. § 552, on the website of the U.S. Office of Government Ethics with ethics agreements of other presidential nominees who file public financial disclosure reports.

I understand that as an appointee I will be required to sign the Ethics Pledge required under the executive order dated January 28, 2017 ("Ethics Commitments by Executive Branch Appointees") and that I will be bound by the requirements and

restrictions therein in addition to the commitments I have made in this ethics agreement.

QUESTIONS SUBMITTED FOR THE RECORD TO SEEMA VERMA

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Thirty million Americans suffer from a rare disease and many of these patients have no therapeutic option to address their condition. Timely access to innovative therapies for these patients with no other viable therapeutic options is critical. How can we ensure that Medicaid drug coverage processes include reviews by clinicians with expert knowledge and experience with the particular rare disease and its patient population?

Answer. If confirmed, I commit to working with you and your colleagues in Congress as well as the FDA and other Federal agencies to prioritize access to innovative therapies for patients, especially our most vulnerable citizens who have unmet medical needs. I look forward to working with clinical experts and relevant Federal entities to ensure patients' needs are at the center of decision making.

Question. CMS invests heavily in the training expenses of psychiatry residents serving in both institutions for mental disease (IMD) and general medical inpatient psychiatric units. But IMDs rules either prohibit the small number of IMD teaching hospitals from serving adults with Medicaid, or restrict IMDs from caring for the most severely ill who need care for slightly longer lengths of stay (15–20) days.

This rule exacerbates the severe national shortage of treatment for people with severe mental illness. Resolving this issue would help with the shortage and would also provide psychiatrists in training with invaluable experience.

How can CMS maximize its psychiatry training investments in IMD teaching hospital settings?

Answer. As you know, the nationwide shortage of physicians and the more general health-care workforce policy questions are central to the health-care challenges our country faces. If confirmed, I look forward to implementing policies to address our Nation's opioid epidemic and improving Americans' access to psychiatric care. As such, I will carefully review and evaluate IMD rules. I should also note that in accordance with my Ethics Agreement, which was previously provided to the Senate, because of my husband's practice as a psychiatrist with the Indiana Health Group, Indianapolis, IN, and his financial interest in the Indiana Health Group, I have agreed not to participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). Under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse myself from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes Indiana Health Group. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

QUESTIONS SUBMITTED BY HON. PAT ROBERTS

Question. Health providers continue to ask for relief from the sheer amount of regulations that they must comply with, but also raise the issue of inconsistency in the application of rules and penalties that they are assessed. This is particularly true for our nursing homes. Ensuring program integrity and protecting our scarce taxpayers dollars are extremely important priorities for the agency. How do we balance those priorities so that we are striving toward quality improvements as opposed to our current enforcement system that is focused more on penalties? How would you work to provide more consistency in how regulations are applied?

Answer. I agree that program integrity and the safeguarding of our scarce taxpayer dollars must be a top priority for CMS. Additionally, the enforcement of rules that health-care providers follow must be done consistently and fairly. In order to better treat and deliver high quality care to patients, health-care providers are better served spending more of their time on health care, and less of it trying to guess

which laws and regulations will be enforced at the discretion of a Federal agency. The fair and consistent application and enforcement of the law will not only protect taxpayer dollars, but it will help enable health-care providers to do what they do best.

Question. Critical access hospitals are required to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. This Condition of Participation was long established and well understood by these key rural safety net providers. However, in the FY 2014 hospitals IPPS final rule, CMS clarified they will also begin enforcing the condition of payment requiring physician certification that each patient will stay for 96 hours or less. Will you commit to reviewing this condition of payment and the effect it has had on our hospitals and beneficiaries in rural areas?

Answer. If confirmed, I look forward to working with you and your colleagues in Congress to ensure that critical access hospitals are best enabled to serve rural populations with the highest possible quality of care. I commit to working with you to review the impact of regulation on hospitals and beneficiaries, especially in rural and frontier areas. Rural providers and their beneficiaries face unique challenges, and CMS should prioritize communication and collaboration with rural providers and stakeholders early on in the regulatory process.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Many States are using section 1115 Medicaid waivers to provide flexibility and modernize their Medicaid program. It can take an average of 323 days from submission to approval, and have a lack of transparency during negotiations which leaves States and stakeholders in limbo.

What do you think can be done to shorten this time frame for approval?

What can be done to make the approval/renewal process more transparent between CMS and States?

What, if anything, should be done to improve oversight of section 1115 waivers?

Answer. The uncertainty around the waiver approval process must change. The flexibility and incentives for States to innovate must be a top priority if we are to better care for our most needy citizens. If I am confirmed, I look forward to working with you to shorten and streamline the waiver approval process. Unfortunately, with the way the system is set up, States must report back to and receive permission from the Federal Government for even routine changes to their Medicaid programs. As a small business owner involved in the waiver process, I can attest that the uncertainty and lack of transparency you describe deters further innovations. As States are forced to spend a great deal of time and resources to receive approval for routine changes or updates to their program, far too often they decide that they don't have the resources or time to pursue more innovative approaches. This is especially important in a State like Texas, which is home to some of the most innovative health-care thinkers and actors in the country. Allowing those health-care organizations the flexibility to innovate, while being accountable to taxpayers and the citizens they serve, will reward reforms that work for patients. I look forward to working with you to improve the waiver process for Texas and other States seeking greater flexibility and consistency in waiver decisions.

Question. Many States have been using waivers or demonstrations to operate portions of their Medicaid programs for years, sometimes decades. HHS estimates that a third of all Federal Medicaid spending is made under demonstrations. Please outline your thoughts (a) on the importance of evaluating the extent to which demonstrations are achieving the objectives of the Medicaid program, and (b) whether continued review and approval of long-standing demonstration projects are necessary.

Answer. If I am confirmed, I will be committed to improving the waiver process and incentivizing innovation over redundant paper-pushing. We will review the extent and role of evaluations as well as the need for waivers for long-standing demonstration waivers that are performing well. States are best equipped to design and understand the unique needs of their own populations, so it is crucial to ensure the successful innovations continue and that even more innovations that prioritize patients' access to quality care are encouraged and tried without duplicative or unnecessary paperwork.

QUESTIONS SUBMITTED HON. RICHARD BURR

Question. Last October, the Centers for Medicare and Medicaid Service (CMS) issued a final rule titled, "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities." The rule was designed to ensure protections are in place for seniors receiving care through these facilities. However, CMS's analysis shows that the cost of implementing these regulations will exceed $800 million in the first year of implementation alone, which could create access issues for patients currently receiving this care.

As Administrator, how do you plan to balance the need for seniors to have access to safe high quality care, while ensuring that health-care providers, including nursing homes and skilled nursing facilities, are able to continue to provide this care to beneficiaries?

What solutions, if any, do you see to decrease compliance costs and ensure access to care and needed protections for seniors?

Answer. I have fought throughout my career for access to quality care, and I appreciate that an insurance card does not equal health care by itself. If confirmed as CMS Administrator, I look forward to working with you to ensure that seniors have access to safe, quality care while also considering the impact of government actions on health-care providers and their ability to serve their patients. It is essential that all CMS actions carefully consider the impact they have on health-care providers and their ability to deliver quality care. I look forward to working with you to implement laws that allow health-care providers to do what they do best: treat their patients. I will work with all parties and stakeholders to protect the doctor-patient relationship and root out inefficiencies so that greater care for patients and innovation may occur.

Question. As you may know, the Patient Access and Medicare Protection Act of 2015 included a provision requiring the Secretary of Health and Human Services (HHS) to submit a report to Congress on the development of an alternative payment model (APM) for certain radiation therapy services this year. As Administrator of the Centers for Medicare and Medicaid Services (CMS), how will you ensure that the agency is engaging with the provider and patient community as it works on this report, and during the development of options for this APM and other APMs for specialty care?

Answer. Communication with providers on the development of the report is paramount to ensuring that the report is successfully completed, and, if confirmed, I will ensure that CMS engages with the stakeholder community.

QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON

Question. As part of 21st Century Cures, Senator Warner and I worked to include a provision that would provide a home infusion services payment for drugs administered through Durable Medical Equipment (DME) covered under Part B. CMS played a critical role in this success by providing thorough technical expertise to assist in the construction of this benefit. This was an enormous first step in allowing patients to receive care in their home at a lower cost than the hospital. I have seen the benefits of home infusion first hand and it is my hope that we will work together this year to expand this policy to antibiotics. I look forward to working with you and your staff to get the data needed to inform the inclusion of infused antibiotic drugs so as to further benefit patients that require home infusion therapy.

Answer. Thank you, Senator Isakson and Senator Warner. If confirmed, I also look forward to working with you both on this priority.

Question. There has been a lot of discussion around value-based pricing as a possible approach to addressing some cost barriers to drugs some patients are experiencing. As you know, currently any drug manufacturers must offer State Medicaid programs the lowest price it offers any other payer, except for Medicare Part D which is exempt from best price.

Do you think value-based drug pricing in Medicaid and other programs should also be made exempt from Medicaid Best Price?

Answer. If confirmed, I look forward to implementing payment reforms enacted by Congress to increase patients' access to medical therapies. I understand the importance of patients having access to life-saving and life-improving innovations. CMS should serve as a faithful steward of taxpayer dollars as it fulfills its role in ensuring Medicaid beneficiaries' access to care.

Question. We are entering a new era where precision medicine can tailor treatments based on an individual's unique genetic makeup and target diseases that impact less than 1,000 patients per year, saving and lengthening lives while reducing unnecessary utilization. This type of innovation especially is critical for patients with rare diseases because in some instances a few extra weeks or months can mean so much to those patients and their families. A concern is that the Medicare prospective payment systems, which have been the underlying Medicare payment structure since the early 1980s, is ill equipped to support our beneficiaries in this new era. My congressional colleagues previously have recognized this shortcoming, and now Medicare has some tools, including New Technology Add-On Payments and Pass-Through Payments for outpatient drugs. However, these programs are temporary fixes lasting only 2 or 3 years.

How can Medicare better incentivize the utilization and remove patient access barriers of innovative treatments currently on the market for rare and ultra-rare diseases?

Does Medicare's current under-reimbursement of innovative therapies for rare diseases send a signal to the patient and provider community that Medicare does not prioritize access and treatment of rare diseases?

Answer. If confirmed, I will work closely with Congress, the FDA, and other entities to ensure that the Medicare program has clear pathways for innovations that benefit patients including the millions of Americans suffering from rare diseases. I appreciate that Medicare should be a partner when it comes to ensuring that beneficiaries have access to cutting-edge therapies. Making sure that Medicare provides access to innovative treatments will be a top priority for CMS if I am confirmed.

Question. I have heard from rehabilitation hospital facilities in Georgia that are concerned about the impact that the implementation of ICD–10 coding is having on a regulation applicable to them called the 60 percent rule. CMS has said there is monitoring of the issue, however there have been no changes made. I would appreciate if once confirmed, CMS review this more closely.

Answer. If confirmed I will review this policy closely and look forward to working with you and your staff to better understand how this impacts health-care providers in Georgia and around the country.

QUESTION SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Since 2005, the Centers for Medicare and Medicaid Services have sought to restrict long-term care hospitals, known as LTCHs, from receiving more than 25 percent of their patients from a single acute care hospital. Worried that this arbitrary threshold would undermine access for very sick seniors to specialty hospitals, especially in non-urban communities, Congress has repeatedly intervened to block this proposal. Most recently, as part of the 21st Century Cures Act, Congress enacted legislation that I authored with Senator Bennet and Nelson to block the 25 percent rule through September.

Beginning later this year, LTCHs will be paid on the basis of a patient's physical condition. This new patient-specific criteria obviates any need to restrict payment on the basis of where the patient came from.

Will you commit to working with my office and other interested lawmakers to make sure that the implementation of the new payment criteria does not include a return to arbitrary thresholds like the 25 percent rule?

Answer. If I am confirmed, I look forward to working with you and your office as well as other members of Congress to develop and implement sound payment policies in accordance with the law. Patient access to quality care in the most appropriate setting for the patient and doctor must be a top priority for CMS.

QUESTIONS SUBMITTED BY HON. DEAN HELLER

MEDICAID BLOCK GRANTS AND PER CAPITA ALLOTMENT

Question. Do you understand why States like Nevada are so concerned with the block grant approach?

How would you design a block grant that would still protect access to care for the Medicaid expansion population?

What is your opinion on reforming Medicaid, so funding is based on a per beneficiary allotment?

Would you take into consideration population growth?

Would you take into consideration the cost of care in rural areas?

Answer. If confirmed, I look forward to working with your office to implement any reform, whether it involves Medicaid block grants, per beneficiary allotments or other innovative ideas, which empowers our most needy citizens with access to quality health care, while supporting innovation efforts at the State level. At the same time, States must be held accountable to standards that result in better health-care quality and access. Ultimately, Congress will decide on any proposals to strengthen the safety net for our most vulnerable citizens, and I look forward to providing any technical assistance that your office or other members of Congress seek in the development of legislative reforms to the Medicaid program.

MEDICAID WAIVERS

Question. What types of reforms have you worked on through the waiver process that you believe has increased coverage for those respective States?

How would you make it easier for States, like Nevada, that did not originally seek a waiver to go through that process and approve the types of reforms needed to protect the 600,000 Nevadans on Medicaid—including 200,000 Nevadans that were eligible through the expansion?

Answer. Innovation starts locally, so if confirmed my job will be to work with Nevada and other States to tailor their Medicaid programs to the unique needs of their citizens. Working through the waiver process at the State level has provided me with the experience to know what works best and what doesn't work as well. I've also been able to learn what the Federal Government asks for and how they ask for it can slow or stop innovation. My experience at the State level reminds me that Washington often doesn't know best; in fact, Nevadans know better how to structure their programs and deliver care to their most needy citizens. I will make it a priority to ensure that Nevada is able to understand the process from beginning to end. Communication and collaboration with your office, other members of your delegation and stakeholders from around the State is crucial. I commit to working closely with you as early and often as needed.

QUESTIONS FROM STATE LEGISLATURE

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

What steps do you plan to take to ensure that the more than 77,000 Nevadans who are eligible for Federal tax credits under the Affordable Care Act to help purchase private insurance will continue to have access to affordable health-insurance options with adequate coverage?

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

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

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

Answer. If confirmed, I will work to ensure that any legislation enacted by Congress is implemented with the utmost care for Nevadans. I am fully committed to ensuring all Americans have access to affordable health care of the highest quality that meets the unique and important needs of their families.

QUESTIONS SUBMITTED BY HON. RON WYDEN

CORPORATE RELATIONSHIPS

Question. As discussed in the hearing and in news media accounts, you and your firm, SVC, Inc., contracted with the following firms: Electronic Data Systems (EDS), Hewlett Packard Enterprises (HP), Milliman, Inc., Highpoint Global, Roche Diagnostics, Health Management Associates (HMA), and Maximus, which provide health-program services and products to the State of Indiana, or represent that they have.[1] Please provide the following for each of these corporate relationships:

The dates you or your firm entered into contracts or subcontracts with each of these companies.

The scope of work you or your firm performed for each contract or subcontract with these companies.

The amount of money you or your firm were paid for work that was completed under each such contract or subcontract.

Answer.

Firm	Dates	Scope	Approximate Revenue
Electronic Data Systems (EDS)[2]			
Hewlett Packard Enterprises	2008–Present	Training, communications, analysis of Federal/State actions	$725,000 (invoices 2011 to present only)
Hewlett Packard Enterprises	2015–Present	Communications assistance specific to Federal/State regulations and compliance	$100,000
Milliman Actuaries	2013–Present	Development of 1115 and 1915c/b waivers	$1,500,000
Milliman Actuaries	2012–Present	1915 waiver development, ACA impact analysis, and policy implementation support	$5,000
Milliman Actuaries	2015–Present	1115 waiver drafting and managed care regulation impact analysis	$150,000
Milliman Actuaries	2013–2014	Technical assistance for waiver implementation	$10,000
Highpoint Global	2016–Present	Provide subject matter expertise for training materials with CMS Assister Program	$350,000
Roche Diagnostics	2010–2012	Development of launch plan related to Accu-Chek platform	$30,000
Health Management Associates (HMA)	2006–2011	Development of uninsured program	$300,000
Maximus	2016–Present	Provide curriculum development support for Maximus Training Services	$10,000

CORPORATE ETHICS AGREEMENTS/DISCLOSURES

Question. For each of the corporate relationships identified in Question 1, please provide the following:

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[1] *Inside Health Policy,* February 10, 2017; *IndyStar,* August 26, 2014; Associated Press, February 15, 2017.

[2] Due to the age of this work, specific responsive information was not located.

Copies of any ethics agreements you entered into with these companies, or ethics guidelines or contract terms you received from these companies, governing conflicts of interest for your engagement with them.

Answer. There were no separate ethics agreements entered into with these companies.

Question. Any documentation showing the processes you were to follow if and when you were to recuse yourself with regard to conflicts of interest involving each company.

Answer. None, and none was required.

Question. Any documentation showing any situations in which you actually recused yourself from matters related to these companies pursuant to these policies, guidelines, or terms.

Answer. None. Other than with respect to HP, there was not a situation for which my recusal was appropriate. I did not supervise any of the work performed by these other companies.

POST-CONFIRMATION CORPORATE RECUSALS

Question. In its annual report to the Securities and Exchange Commission, Maximus says they are the largest provider of Medicaid and CHIP enrollment services in the United States.[3] In the same filing, Maximus states that HP is one of their major competitors in the health services sector. You have current contracts with both of them. As you've reported on OGE Form 278, you also have current contracts with HighPoint Global and Milliman, Inc. All four engage in activities funded through CMS. Your Ethics Agreement states you will need to get special approval to consider matters involving seven of the States for which you did consulting work, but it is completely silent on the question of what is required for you to consider matters involving your consulting work for these companies. The only specific corporate recusal in your Ethics Agreement relates to HMA, which is buying your consulting firm. Please describe your understanding of the extent to which you would need to recuse yourself from matters involving these other four companies.

Answer. My understanding is as stated in my Ethics Agreement and the Ethics Pledge. These documents are quite specific regarding my ethical obligations with respect to these four companies. My Ethics Agreement states: "I will not participate personally and substantially in any particular matter involving specific parties in which I know ***a former client of mine is a party or represents a party,*** for a period of 1 year after I last provided service to the client, unless I am first authorized to participate pursuant to 5 CFR § 2635.502(d)" (emphasis added). The Ethics Pledge states: "I will not for a period of 2 years from the date of my appointment participate in any particular matter involving specific parties that is directly and substantially related to my former employer or former clients, including regulations and contracts."

STATE OF INDIANA CONTRACTS

Question. Please identify, by contract number and date, each of your contracts with the State of Indiana and any related amendments thereto. Also, please provide the total award value of those contracts, to the present, and the total revenue amount from those contracts, to the present.

Answer.

Contract Number	Date	Amendment(s)	Award Value
57464–000	July 19, 2011	57464–001 57464–002 57464–003 57464–004 57464–005 57464–006	$2,978,527

[3] Maximus, Inc. SEC 10–K, November 21, 2016.

Contract Number	Date	Amendment(s)	Award Value
80287–000	July 23, 2014	80287–001 80287–002 80287–003	$4,851,400

The approximate revenue from these contracts to date is $5.3 million.

OVERSIGHT OF CONTRACTORS IN INDIANA

Question. According to a recent press report, you were a member of a "group of health officials" that unsuccessfully pitched former Governor Mitch Daniels on health reform in 2006. You were also identified as "leading" that same group when it later successfully convinced Daniels to move forward with health-care reform.[4] In your biographical materials, you have also discussed your role as the architect of the Healthy Indiana Plan (HIP). As discussed in the hearing, it appears that you were advising the State at the same time that you had contracts with other vendors, including HMA. You also provided the committee with a statement from then-Secretary of the Indiana Family and Social Services Administration (FSSA) John J. Wernert, which included the sentence: "Additionally, no consultant is allowed to oversee the work of a contractor with whom they have a separate professional relationship."

It appears that on or about May 1, 2006, you and your firm became a subcontractor to HMA on a contract HMA held with the State of Indiana to provide consulting services to FSSA. A May 1, 2008 amendment to a contract between Indiana and HMA shows that you received payments from the consulting firm for subcontract work beginning May 1, 2006.[5] The original May 1, 2006 contract does not appear to be available in the State's public disclosure database. Please provide a copy of the original HMA contract with the State and a description of the scope of work HMA performed and that you performed under that contract, as well as under the subsequent contract amendment.

Answer. A copy of the contract has been provided to the committee. Under that contract, HMA developed an uninsured program for the State of Indiana. The scope of work that SVC performed solely included provision to HMA of professional consulting services related to HMA's development of that uninsured program. I did not oversee HMA's work on this contract.

Question. On or about January 22, 2007, your firm received a sole source FSSA contract for coordinating development of a Request for Proposal to procure the services of a vendor to administer the "Governor's Plan for a Healthier Indiana."[6] That same day, HMA received a sole source FSSA contract to develop and draft the Request for Proposal for the "Governor's Health Care Plan."[7] It appears that the work scope in your contract required you to oversee the work of HMA contrary to FSSA policy. Please provide the following:

A description of the work you performed under your contract with the State.

Answer. It is not correct that the scope of work in the SVC contract included oversight of the HMA work under its contract. SVC and HMA had parallel but distinct roles, both under the oversight of State officials. Through SVC, I provided consulting services regarding preparation of an RFP for a vendor to administer the Governor's Plan for a Healthier Indiana. I provided project management services, technical assistance to contractors and to FSSA, and other assistance to the State in its development of the RFP, including reviews of drafts of the RFP.

Question. The justification provided for SVC, Inc. having been awarded a non-competitive contract.

Answer. The justification, as drafted and approved by State officials, was: "The contractor has been involved in the development of The Governor's Plan for a Healthier Indiana from its inception, and has intimate knowledge of its many parts. With the rapid timeframe required to develop the RFP, the State does not have the resources to bring another consultant up to speed. SeemaVerma Consulting is Indiana-based and has keen knowledge of the Indiana health care market place, which

[4] CNN, February 16, 2017.
[5] Indiana SVC Contract (EDS: A129–6–49–06–XE–2020).
[6] Indiana SVC Contract (EDS: A129–7–49–07–XE–2730).
[7] Indiana Health Management Associates Contract (EDS: A129–7–49–07–XE–2020).

will be critical to developing the RFP. We have worked with her over the past 2 years and feel very comfortable with the quality of her work product."

Question. A description of your understanding of the scope of work that HMA was to perform and an explanation of how you interacted with HMA on this task.

Answer. As stated in HMA's contract, HMA was to "[D]evelop the draft and final version of the 'Request for Proposal' for the Governor's Health-Care Plan. The contractor will review current commercial carrier Health Savings Account Plan structures, propose alternatives and opinions, conduct research as necessary, assure compliance and coordination with existing FSSA regulations, and provide technical assistance as required by FSSA or its contractors."

Question. A description of any role you played, if any, in the award of this HMA contract, including any documentation of any recusals related to the award or performance of this contract.

Answer. I had no role in the award of the HMA contract.

Question. Please explain how you coordinated development of the State's RFP for HIP while HMA—with whom you had a prior financial relationship—drafted that RFP, without violating FSSA policy as described in Secretary Wernert's statement.

Answer. As the contracts make clear, I worked in conjunction with HMA on this effort, but I did not oversee its work. When the State of Indiana develops RFPs for something as large and important as the Governor's Health-Care Plan, it often procures services from several vendors who are assigned distinct tasks; that was the case here, such as actuarial services, and procurement specialists.

Question. A fourth amendment to the HMA contract, prepared on April 20, 2012, appears to show that HMA billed Indiana for work with the Office of Medicaid Policy and Planning (OMPP) including for your firm's hourly rate from May 1, 2010 to June 30, 2011.[8] Please provide the following:

Question. A description of the consulting work performed under this contract by HMA for OMPP.

Answer. HMA provided "financial and/or business consulting services related to health-care services to four (4) divisions of FSSA." Full details of the scope of these services are provided in the amendment to the contract.

Question. Confirmation of whether you and your firm were an active subcontractor on this contract during this period, or in the alternative, please provide the period of performance by you and your firm.

Answer. Confirmed.

Question. A detailed description of the scope of work SVC, Inc. performed under this contract, specifically with OMPP between May 2010 and June 2011, and revenue received.

Answer. HMA and its subcontractors provided consulting services to Indiana Family and Social Services Administration in four areas: Transformation of Aging Services and operational and programmatic work for the Division of Aging; operational and financial management services for the Division of Mental Health and Addiction; and waiver system administration for the Office of Medicaid Policy and Procedures. The revenue received by SVC, Inc. between May 2010 and June 2011 for this subcontract was approximately $500,000.

Question. Any documentation showing if you recused yourself when potential conflicts arose under this contract.

Answer. None. There was no potential conflict for which recusal was necessary or appropriate. SVC's separate work for FSSA did not involve oversight of this HMA contract, and SVC played no role in FSSA's decision to award the contract to HMA.

Question. In December 2007, EDS was awarded a contract to "provide fiscal agent services for the Medicaid program for FSSA." You were included in the EDS contract, and paid through this contract as a subcontractor.[9] These contracts were subsequently continued through HP. On February 21, 2012, an existing 2011 SVC, Inc. contract was increased by $475,000 and amended to broadly increase the scope of

[8] Indiana SVC Contract (EDS: A129–6–49–06–XE–2020).
[9] *Id.*

SVC's work, including specifically overseeing "MMIS (HP) technical changes."[10] It appears that the scope of work in this expanded contract required you to oversee work performed by HP contrary to FSSA policy. Please provide the following:

A description of the work, you performed under this contract with the State of Indiana with regard to MMIS.

Answer. Regarding MMIS, SVC worked with the State of Indiana and its vendors, including HP, to design systems for implementation of the Healthy Indiana Plan. We helped vendors translate the policy and waiver language into system operations. We did not oversee HP or any other vendor in this regard, and did not negotiate or participate in change orders or contract amendments. To the best of my recollection, State officials participated in all meetings with HP regarding the Healthy Indiana Plan work at which SVC representatives were also present.

Question. A description of your understanding of the scope of work that HP was to perform and an explanation of how you and your firm carried out your work regarding HP on this task.

Answer. HP prepared systems for the implementation of the Healthy Indiana Plan and all Medicaid programs. My firm and I worked with HP and the State's other vendors on this task, helping them to understand the program so they could make the appropriate technical changes to the system. In addition, please see the previous answer.

Question. A description of the work you and your firm performed under the EDS/HP contracts.

Answer. My firm and I performed a substantial amount of work on a variety of subjects; a comprehensive description of the scope of work is contained in the contract.

Question. Documentation of any recusals related to the performance of your State of Indiana contract with regard to EDS/HP.

Answer. None, and none was required.

STATE OF INDIANA ETHICS PROCEDURES

Question. In response to Senator Wyden's question regarding conflicts of interest during your time working with the State of Indiana, you responded that you recused yourself from meetings in which a potential conflict could arise: "I've been in meetings, where we were talking about contractors and talking about implementing a program. And when it came to a vendor that we had a relationship with, I would recuse myself. I would get up and leave the meeting so that there was never any issue."

In a written response—to the 2014 Indianapolis Star article regarding Hewlett Packard—provided to the committee, you similarly stated "(i)f any issue between HP and the State presented a conflict between the two, I recused myself from the process."

Please describe the process for determining when a matter constituted a conflict. What agency official or officials determined such a conflict existed?

Answer. Consistent with the ethics opinion that I received, I recused myself from any matters related to HP's contract, the scope of its work, any change orders, its compensation, etc. Agency officials were fully aware of and supported this approach. I do not recall any other formal determinations regarding potential conflicts.

Question. Please provide any written policies, agreements, or other communications documenting the nature of this conflicts process.

Answer. None.

Question. Did this process apply to all of your clients, namely EDS, HP, Milliman, HMA, Roche Diagnostics, and Maximus? If not, which clients were not subject to this process and why?

Answer. Yes, I was alert to potential conflicts regarding all of my clients.

Question. You have stated that you did recuse yourself. In which instances did you do so? Were these recusals documented? And if so, please provide this documentation.

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[10] IN Contract EDS: A129–1–29–11–ZN–1758 (first amendment).

Answer. I recused myself from any matters related to HP's contract, the scope of its work, management issues, any change orders, etc. If these issues arose during a meeting, I would remind the State employees of my relationship with HP and made clear that I would not be involved, and would leave the meeting.

Question. In 2012, you requested an ethics opinion from the Indiana Ethics Commission with respect to your work for Hewlett Packard. Did you request ethics opinions for your work with EDS, Milliman, Inc., HMA, Roche Diagnostics, or Maximus? If so please provide copies of those opinions.

Answer. No. The scope of SVC's work for those other companies was narrower than the work involving HP.

Question. Please provide copies of any ethics agreements you entered into or ethics guidelines or contract terms you received from the State of Indiana for your work with the State governing conflicts of interest.

Answer. None, other than that previously provided.

REPRESENTATION BEFORE STATE AGENCIES

Question. In two separate news articles, the former head of the FSSA in Indiana, Debra Minott, indicated that you represented Hewlett Packard in a billing dispute before a State agency—FSSA—for which you were a consultant. In an *Indianapolis Star* article, dated August 26, 2014, which Senator Wyden quoted in the hearing, Ms. Minott is herself quoted:

"We had delayed paying an HP invoice because of an issue we were trying to resolve, and HP sent Seema to our CFO to resolve the issue on their behalf," Minott said. "I was troubled because I thought Seema was our consultant."

That article was updated and republished on November 29, 2016. More recently, the Associated Press published a story on Feb. 14, 2017, in which Ms. Minott reiterated that you had represented HP in this dispute. The AP article states:

"It was never clear to me until that moment that she, in essence, was representing both the agency and one of our very key contractors," said Minot(t), who was removed as head of the agency by Pence over her disagreements with Verma. "It was just shocking to me that she could play both sides."

Did you represent HP in a billing dispute with the FSSA as reported?

Answer. No. The only source for this allegation is Ms. Minott, a disgruntled former employee; to my knowledge, no one else has provided support for her assertions. Indeed, HP has made clear, as stated in the same AP article, that "it can find no one in its company with any recollection of such a meeting."[11] Further, Ms. Minott participated in a tour and briefing at HP's facilities on November 21, 2013 in which the HP–SVC partnership was specifically discussed and written materials were provided that documented the relationship. With that knowledge, Minott approved increases in the amount of SVC's contracts with the State thereafter. At no time during her tenure at FSSA did Ms. Minott ever express any concerns to me about SVC's work for HP.

Question. Did you ever represent HP in any other matter before any Indiana agency or office? If so, when and in what capacity?

Answer. No.

Question. Did you ever represent any other client, specifically EDS, HMA, Milliman, Roche Diagnostics, or Maximus, in any matter before FSSA or any other State agency or office? If so, when and in what capacity?

Answer. No.

WAIVER TRANSPARENCY

Question. The ACA required HHS to issue regulations that ensure the public has a meaningful opportunity to provide input on proposed section 1115 waivers, including new applications and applications for waiver extensions. The rule HHS promulgated in February 2012 requires States to provide a 30-day public notice and comment period, set up a website for their proposal, and hold public hearings around

[11] *http://www.indystar.com/story/news/politics/2014/08/25/powerful-state-healthcare-consultant-serves-two-bosses/14468683/*.

the State, among other provisions. States are also required to submit an annual report to HHS that includes an evaluation of the changes' impact.

Do you believe that the details of a State's waiver request should be made available to the public in advance of the State submitting the waiver request to CMS?

Do you support requirements for the State and CMS to obtain and respond to public comments prior to a State deciding on whether to submit or CMS to approve or deny the request?

Will you maintain the section 1115 transparency provisions that seek to improve public accountability and bring waiver negotiations from behind closed doors?

What additional steps will you take to ensure public participation in the waiver process and transparency in the negotiations between CMS and States seeking waivers?

Will you continue CMS's current practice of timely posting of waiver applications, approvals, and all supporting documents on the CMS website?

Will you require that every waiver application at a minimum provide a description of the demonstration and a specific listing of the waiver authorities requested and the intended use of the waiver requested?

When issuing approvals, will you require that these approvals specifically list the waiver authorities that are approved and their approved use?

Do you think amendments should be subject to the same transparency requirements?

Answer. If confirmed, transparency and consistency in the waiver process will be priorities for CMS. It is imperative that States are able to partner with CMS in a joint effort to update and modify their Medicaid programs to better serve their citizens. Clear and fair rules of the road are crucial for States' planning purposes as well as for the longevity and success of their Medicaid programs. If States are mired in paperwork and forced to redirect resources to unnecessary Federal requirements, that means less resources are available to their most needy citizens. I pledge to work with States to make this process easier, more transparent and more efficient for both States and all impacted parties. Additionally, it is crucial that stakeholders receive an opportunity to provide input, so I look forward to communicating and collaborating with them, whenever appropriate.

PRESIDENT'S JANUARY 20TH EXECUTIVE ORDER

Question. On January 20th, the President issued an executive order instructing the Secretary of Health and Human Services and the heads of all agencies—which includes the CMS Administrator—to do everything possible to roll back the Affordable Care Act (ACA). If confirmed as CMS Administrator, you will be responsible for carrying out this executive order.

Based on your understanding, what are the specific actions that the CMS Administrator could take to carry out the President's January 20th executive order regarding the ACA?

If confirmed, which of those actions would you take as CMS Administrator to carry out the President's order?

Answer. If I am confirmed, I plan to review prospective options with CMS staff and others within HHS and the administration to better determine what can be done to undo or mitigate the harms created by the ACA. Once I evaluate the options, we will act accordingly to help Americans suffering from higher costs, fewer choices, and less access to quality care.

PRESCRIPTION DRUG PRICES

Question. Ms. Verma, during your nomination hearing I asked for one specific action you would take as CMS Administrator to curb the rising prices of prescription drugs, but you did not provide one specific idea.

As CMS Administrator you will have broad power, independent of Congress, to impact the cost of prescription drugs. For example, each year CMS publishes the Part D Call Letter and Rate Notice and also is able to propose changes to regulations regarding payment for physician administered drugs. Within CMS, the Center for Medicare and Medicaid Innovation also has broad authority to test new payment models that could involve prescription drugs.

Please provide one specific action you would take as Administer to address the rising costs of prescription drugs.

Answer. I appreciate that drug costs are an important pocket-book issue for many Americans. If confirmed, I will work with the CMS staff to evaluate potential options and ensure that beneficiaries' access to high quality and affordable drugs is a top priority for CMS. I look forward to reviewing relevant implementation issues, including items such as PBM contracts, when appropriate.

MEDICAID REFORM AND OPIOIDS/SUDS

Question. Opioid abuse (including heroin and prescription pain relievers) is contributing to a public health epidemic of significant consequence. In 2015, there were 20,101 prescription drug-related overdose deaths and 12,990 heroin-related overdose deaths. Medicaid is the primary payer for all substance use disorder services in the country and will be critical in the fight against the opioid epidemic.

Thanks to Medicaid expansion under the Affordable Care Act (ACA), an additional 11 million adults now have access to Medicaid. Over one million of these adults gained access to treatment for opioid abuse and other substance use disorders (SUDs). In States that expanded Medicaid, there are more physicians who can prescribe the drugs needed (*e.g.,* buprenorphine) to help individuals overcome their addiction to opioids. Without the Medicaid expansion, fewer people would have access to Medication-Assisted Treatment (MAT) for opioid abuse and other substance abuse treatment. Furthermore, the ACA included addiction treatment as an essential health benefit that must be covered in all health plans.

Will you commit to advising against repeal of the Medicaid expansion resulting in over a million Americans with SUDs losing access to essential addiction treatment services?

Answer. It is critical that all Americans suffering from mental health and substance abuse disorders have access to the care they need. If confirmed, to the extent I am not required to recuse from a particular matter under the terms of my Ethics Agreement, I am committed to ensuring that access is not diminished.

Question. Will you commit to advising against cuts to State Medicaid programs through block grants and per capita caps that put individuals struggling with SUDs at risk of losing access to their Medicaid coverage or benefits?

Answer. I support ensuring Americans have access to quality health care. It is critical that all Americans suffering from substance abuse disorders have access to the care they need. If confirmed, to the extent I am not required to recuse from a particular matter under the terms of my Ethics Agreement, I am committed to ensuring that access is not diminished.

Question. Will you commit to ensuring States are required to cover behavioral health benefits such as treatment for SUDs as they cover services for physical health conditions?

Answer. If confirmed, I will implement the law as designed by Congress and I look forward to realizing reforms that put patients and their doctors in charge of their health care decisions, whether they involve physical or mental health conditions. As noted in my Ethics Agreement, referenced above, because of my husband's practice as a psychiatrist with the Indiana Health Group, Indianapolis, IN, and his financial interest in the Indiana Health Group, I have agreed not to participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). Under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse myself from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes the Indiana Health Group. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. What are your specific plans to address the opioid epidemic? What role should CMS play in this fight?

Answer. If confirmed, I will work with CMS to ensure that Americans suffering from mental health and substance abuse disorders have access to the care they

need. Americans in CMS programs should have access to high quality health care and I look forward to partnering with HHS and other departments and agencies to address the opioid epidemic.

MEDICAID LOCK-OUT

Question. During your nominations hearing, I asked about your Healthy Indiana Plan (HIP) 2.0.

Will Indiana be able to maintain eligibility under HIP 2.0 if the Medicaid expansion is repealed or if Federal financial support of the expansion population is drastically reduced?

Answer. I cannot speculate as to what impact legislative changes that Congress has yet to make will have on Indiana's Medicaid program.

Question. To clarify for the record, does your Healthy Indiana Plan 2.0 lock out an individual making $12,000 a year from coverage if they cannot pay their premium for 2 months?

Answer. The State of Indiana's Healthy Indiana Plan's contribution requirements are not designed as a punitive measure but as a way to promote personal responsibility among members which has resulted in better health outcomes than traditional Medicaid. Only members above the poverty line are at risk of losing coverage for non-payment. Where HIP members are locked out of coverage for 6 months for non-payment, those who fail to pay Marketplace premiums may have to wait until the next open enrollment period to regain coverage, which can be up to 9 months, unless they have a change in circumstance that makes them eligible for a special enrollment period. On whole, HIP's non-payment policies for individuals above the poverty line are at least comparable to, if not more lenient than, the policies governing the Marketplace. Moreover, only 5 percent of former HIP members indicated they left the program due to affordability issues. Additionally, more than 80% of HIP members have indicated they would be willing to pay more to stay in the program, while more than half of those who left the program due to non-payment successfully transitioned to private health insurance coverage.

FAMILY PLANNING

Question. Medicaid is the largest payer of reproductive health care and provides coverage to approximately one in five women of reproductive age. Family planning services and supplies, in particular, are provided special protections under the law. Not only are family planning services and supplies a mandatory covered service for both traditional and expansion populations, but Federal law also protects the ability of Medicaid beneficiaries to choose any qualified family planning provider who participates in the Medicaid program, even if they are not in a health plan's network. The Federal Government matches family planning services at a rate of 90 percent to ensure that States provide robust coverage of birth control methods and related services.

Do you commit to maintaining the requirement that Medicaid beneficiaries have the freedom to choose their family planning service provider?

Answer. As a woman, I support ensuring access to health care for both women and men and a health-care system that will provide access to quality care while ensuring patients are able to make decisions that work best for them.

Question. Do you commit to ensuring that family planning services, including access to a person's preferred contraceptive methods, including IUDs, birth control pills, and implants, will remain available to all women?

Answer. I support a health-care system that will allow women to make the decisions about what works best for them.

Question. Do you commit to maintain the 90-percent Federal matching rate for family planning services?

Answer. Changes in the Federal matching rate are determined by Congress, so I look forward to enforcing the law as written by Congress.

BEHAVIORAL HEALTH

Question. Ms. Verma, during your nomination hearing you did not answer Senator Menendez's question regarding essential health benefits and children with autism because you are recusing yourself from the topic of behavioral health due to your

husband's profession as a psychiatrist, pursuant to your Ethics Agreement. In order to clarify the issue, please answer the following:

What specific actions as Administrator will you be required to recuse yourself from that involve behavioral health? For example, implementation of MACRA involves physicians treating patients with behavioral health. How would you separate behavioral health issues from other patient groups while working on physician payment issues?

Answer. As noted in my Ethics Agreement, which was previously provided to the Senate, because of my husband's practice as a psychiatrist with the Indiana Health Group, Indianapolis, IN, and his financial interest in the Indiana Health Group, I have agreed not to participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). Under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes Indiana Health Group. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. Will you meet with advocates for and providers of behavioral health care?

Answer. If confirmed, there will be certain situations where I would be able to meet with a particular provider of behavioral health care (or its advocates) and certain situations where I will be required to recuse. For example, if one specific provider of behavioral health-care services, that is not the Indiana Health Group, requests a meeting to discuss settlement of litigation against that provider, I would be able to meet and listen to that provider's concerns. On the other hand, if a group of behavioral health-care providers, requests a meeting with me to discuss health insurance coverage in the small group market for mental health services as an essential health benefit (EHB), I would recuse from this meeting. If I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. Behavioral health also includes substance abuse, including addiction to opioids. Are you recusing yourself from any issue related to opioid abuse?

Answer. As noted above, under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes Indiana Health Group. There will be certain situations where I would be able to participate in substance abuse matters and certain situations where I will be required to recuse. The analysis of my recusal obligation for a particular matter will be made on a case by case basis. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. What other specific patient types and/or issues will you recuse yourself from because of your husband's medical practice?

Answer. If confirmed, because of my husband's practice as a psychiatrist with the Indiana Health Group, Indianapolis, IN, and his financial interest in the Indiana Health Group, I have agreed not to participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). Under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes Indiana Health Group. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. For each area you are recusing yourself, please provide the names and/or positions of the individual to whom you expect to delegate responsibility for such issue on behalf of CMS, or do you intend to seek waivers from the recusal requirement?

Answer. If confirmed, matters from which I am recused will be elevated to the HHS Deputy Secretary or the HHS Chief of Staff, as appropriate, for disposition without my input or recommendation. Additionally, once they are appointed I would designate certain members of my administrative staff and other appropriate CMS officials within my immediate office to screen matters that are covered by my recusal obligation, so that these matters are not given to me for action.

ALTERNATIVE PAYMENT MODELS IN MEDICARE

Question. The previous administration set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payments by the end of 2016 and tying 50 percent of those payments to alternative payment models by the end of 2018. CMS achieved its goal to alternative payment models into 30 percent of Medicare payments in March 2016—9 months earlier than expected.

Will you commit to supporting the previous administration's goal of making 50 percent of Medicare payments through alternative payment models by 2018?

If so, what specific actions will you take—if confirmed as CMS Administrator—to reach that goal?

Answer. I look forward to reviewing the actions taken by health-care providers and CMS to achieve this goal in order to determine what has worked and what we can improve upon going forward. Additionally, it is crucial that we communicate with providers and stakeholders and seek their input as early in the process as appropriate.

ACTUARIAL SOUNDNESS AND NETWORK ADEQUACY IN MEDICAID MANAGED CARE

Question. In the final Medicaid Managed Care rule, released in May 2016, CMS strengthened actuarial soundness requirements for plans that contract with State Medicaid programs to provide health-care services. The actuarial soundness provision requires States to pay health plans at a rate that is sufficient to provide, "for all reasonable, appropriate, and attainable costs," that are required under the terms of the contract and for successful operation of a managed care entity providing services to Medicaid beneficiaries. The final Medicaid Managed Care rule included provisions to increase the transparency and accountability in the development of health plans' capitation rates.

The final rule also includes important beneficiary protections. The new rule proposes important changes to increase the adequacy of provider networks in Medicaid managed care. States are required to set "time and distance" standards to limit how long or how far a Medicaid beneficiary has to travel in order to receive services from all types of providers. For long-term services and supports (LTSS) providers, who travel to beneficiaries, States must set similar time and distance standards. In addition, States must establish continuity of care policies for beneficiary transitions into or between managed care plans.

Do you commit to maintaining the actuarial soundness requirements in the provision of Medicaid managed care?

Do you commit to maintaining the increase in transparency and accountability in the capitation rate development process?

Do you commit to maintaining time and distance standards to strengthen network adequacy for Medicaid managed care enrollees?

Do you commit to maintaining the requirement for time and distance standards to be applicable to the 11 categories of providers specified in the final rule?

Do you commit to maintain the requirement for States to consider the number of network providers who are not accepting new patients, the geographic location of network providers, the ability of network providers to communicate in non-English languages, and the ability of network providers to ensure accessible, culturally competent care to people with disabilities when setting their time and distance standards?

What specific actions will you take to assure proper oversight of the implementation of the final Medicaid Managed Care rule?

Answer. If confirmed, I commit to thoroughly reviewing the rule with the utmost regard for the accessibility of high-quality health care for all impacted Medicaid beneficiaries as well as State flexibility, efficiency, and cost effectiveness.

PERIODIC UPDATES REGARDING AFFORDABLE CARE ACT OUTREACH AND ENROLLMENT

Question. At Marilyn Tavenner's confirmation hearing for CMS Administrator, Chairman Hatch asked her to commit to providing bi-weekly updates on the establishment of the Affordable Care Act (ACA)'s Exchanges and on enrollment. I request that you make a similar commitment to provide periodic updates to the Finance Committee.

Will you commit to providing the members of the Finance Committee with periodic updates—both written progress reports and briefings—in the months leading up to and during ACA open enrollment periods?

In addition to any available enrollment numbers, I would ask that those updates address technology functioning; marketing and outreach plans; operation of the call center, in-person assistance and staff working with the States; and any improvements or changes being made to the enrollment process. Do you agree?

Answer. If confirmed, I am committed to working with Congress to ensure you are updated on CMS activities. If I am confirmed, communication and collaboration with Congress will be a major priority for me and the agency.

1115 WAIVERS

Question. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain statutory requirements of major health programs such as Medicaid as long as they further the purposes of the program. States have historically used waivers to expand coverage, strengthen benefits, and innovate in payment and delivery systems.

Do you agree that section 1115 experimental projects must "promote the objectives of the Medicaid Act?"

Do you agree that the objective of the Medicaid Act is to furnish medical assistance to low-income people and to furnish "rehabilitation and other services to help such . . . individuals attain or retain capability for independence or self-care?" (42 U.S.C. § 1396–1).

Do you agree that a proposal that will clearly reduce access to medical assistance is inconsistent with the objectives of Medicaid?

Do you agree with the criteria the Centers for Medicare and Medicaid Services (CMS) currently uses to evaluate when a demonstration project promotes the objectives of Medicaid—that the demonstration will: increase and strengthen overall coverage of low-income individuals in the State; increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the State; improve health outcomes for Medicaid and other low-income populations in the State; or increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks?

Answer. I agree that experimental projects and demonstrations within the Medicaid program should reflect the overall objectives of the program, as defined by Congress. If confirmed, I look forward to reviewing any proposal put before me to determine whether and how it could impact beneficiaries in addition to ensuring the demonstration project is budget neutral to the Federal Government.

PRESIDENT'S JANUARY 30TH EXECUTIVE ORDER

Question. On January 30th, the President signed an executive order requiring the Federal agencies revoke two existing regulations during fiscal year 2017 for every new rule they issue.

On Wednesday, February 15th, CMS released a proposed rule regarding the individual and small group health insurance markets.

If confirmed as CMS Administrator, which two existing CMS rules or regulations would you repeal to account for the release of this proposed rule?

For additional rules that CMS is statutorily required to publish this year, if confirmed as CMS Administrator, would you require that CMS publicly identify which two regulations it plans to repeal at the same time as the new rule is proposed? If not, within what timeframe will those two regulations be identified?

What are some examples of current rules you would eliminate to comply with the arbitrary two for one rule reduction requirement? Would you rescind rules to comply with the executive order that protect public health or patient safety? How would you determine which rules would be rescinded when new rules are issued?

Answer. If confirmed, I will work with HHS and CMS staff to review all rules and regulations and ensure compliance with the President's executive order.

HOME- AND COMMUNITY-BASED SERVICES

Question. Federal Medicaid law provides States with flexibility to provide long-term services and supports (LTSS) through home- and community-based services (HCBS) rather than in nursing homes or other long-term care facilities. To date, almost every State offers HCBS services to older adults and people with disabilities through waivers. HCBS waiver programs have helped 1.5 million Americans stay at home rather than move into a nursing home.

Section 2401 of the Affordable Care Act also authorized the Community First Choice Option to provide home- and community-based services for people who otherwise would have to move into a nursing home. To encourage States to adopt the program, Federal financial participation is increased by 6 percent. Today, 8 States, including Oregon, and over 300,000 people are served by the program.

Baby boomers are reaching retirement age, and Americans are living longer. By 2030, older Americans will account for 20 percent of the Nation's population. As a result, the demand for long-term services and supports including those offered at home and in the community is expected to increase dramatically.

Do you think the Federal Government should help States address the needs of a high-cost, aging population?

How do you think HCBS wait lists will fair with a 30-plus-percent cut to Medicaid funding through block grants or per capita caps, which HHS Secretary Price proposed in his 2017 budget proposal as House Budget Committee chairman?

Do you support extending the Money Follows the Person program at current funding levels?

Do you support the Community First Choice State option with the current Federal matching levels?

Answer. Long-term services and supports are a vital part of the Medicaid program and will increase with the aging baby boomer population. I look forward to reviewing CMS's previous actions and prospective options to ensure our commitment to Americans with long-term care needs is met and that States have the flexibility to implement innovative programs that work best for the populations they serve.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

Question. Because of Medicaid expansion in Michigan, 650,000 people have insurance, and uncompensated care has been cut by at least 50%. Thirty thousand jobs have been created, and the State will end the year with $432 million more than it invested in the program. Unfortunately, the one thing in common about every Republican proposal in front of Congress right now is cuts to Medicaid funding.

Do you support cutting funding to States to run Medicaid programs?

Answer. I support ensuring all Americans have access to quality health care. Medicaid's financing structure is determined by Congress, so I look forward to collaborating with Congress and implementing the law as written.

Question. A repeal of Medicaid expansion in addition to the block grant proposal supported by Speaker Ryan, Secretary Price, and many others would cut about $2 trillion from the Medicaid program over the next 10 years.

Having worked closely with States and State budgets, including working with Michigan during implementation, if the Medicaid program was cut by $2 trillion how would you advise Michigan absorb the loss?

Do you think it is possible to do without dropping eligibility, cutting services and providers, or raising State taxes?

Waivers are used to promote innovation—how do you innovate without harming people if your budget is being decimated?

When you talked about State flexibility from Federal regulations, should that include the ability to not follow Federal mental health parity law?

Can you commit that you would not approve any waiver or regulation that reduces mental health protections under the Medicaid program?

Answer. If confirmed, to the extent that I am not required to recuse from a specific waiver or regulation under the Ethics Agreement I signed on January 31, 2017, I would evaluate each waiver that is elevated to the level of the CMS Administrator to ensure it meets the requirements set out by law and to evaluate its impact on beneficiary access as well as budget neutrality requirements.

Question. During the ACA debate, I was the lead sponsor of a provision that ensured maternity and newborn coverage would be guaranteed for women and their babies. Last Congress I led a bill with Senator Grassley called the Quality Care for Moms and Babies Act, which passed the Finance Committee. The bill would address performance measurement gaps in Medicaid and CHIP and create maternity care quality collaborates to share and adopt best practices.

Can you commit to work with me on this legislation, and work on driving down the maternal mortality rate?

Answer. If confirmed, CMS will be happy to provide technical assistance related to this legislation as well as other priorities of yours. Improving maternal and child health outcomes has been something I have focused on in my career, so I look forward to working closely with your office on matters of great importance, such as the maternal mortality rate.

Question. More generally, do you agree that it is critical to continue investing in health-care-quality improvement and measurement? How would you engage stakeholders from across the health-care system to participate in the effort?

Answer. I believe that we should constantly be monitoring data and outcomes to ensure that patients are receiving quality care that improves health-care outcomes.

Question. One of the greatest threats to the Medicare program is Alzheimer's disease. We need a cure and research dollars to help us get there, but we also need the Medicare program to provide coordinated, thoughtful care to people living with Alzheimer's disease and their caregivers who shoulder so much of the burden. We made progress last year, as I was able to get a care planning benefit included in the program, which will help ensure better delivery of care.

Do you agree we could help shore up Medicare financing by tackling Alzheimer's disease care?

What steps would you take as CMS Administrator to help families struggling with the diagnosis of Alzheimer's disease?

Answer. If confirmed, I stand ready to partner with Congress, the FDA, NIH, and stakeholders to ensure that Medicare beneficiaries suffering from Alzheimer's are treated with dignity and compassion. Curing Alzheimer's would revolutionize the American health-care system for the millions of families impacted by this disease.

Question. The Patient Access and Medicare Protection Act helped stabilize patient access to radiation oncology services delivered in community-based clinics. The legislation also requested a report from CMS on the development of alternative payment models in radiation oncology by this summer. Radiation oncologists in my State are currently working to develop alternative payment models that incentivize high-quality care for cancer patients.

As Administrator, how would you consult with radiation oncology stakeholders, and others, on the development of APMs to ensure stability, patient access, and appropriate reimbursement?

Answer. If confirmed, I would ensure that CMS is consistently engaging stakeholders as policies and programs are developed and implemented to ensure we are achieving the best outcomes for patients. It is critical that we have open communication to understand their perspective, what they are going through, and what their challenges are.

Question. How would changes to the Medicaid financing structure, such as a block grant system, affect Indian health programs?

Answer. Every State is unique with a different population and different needs. Congress ultimately decides how to reform Medicaid's financing structure, and I look forward to implementing whichever reforms they enact with the utmost care for those affected by those changes, including families in Indian health programs.

Question. Would you protect the 100% FMAP for services provided through an IHS/Tribal facility?

Answer. If confirmed, I look forward to implementing the law as written by Congress. Questions related to the percentage of Federal assistance are determined by Congress, so I stand ready to work with you and the rest of Congress to ensure the law is implemented appropriately.

Question. In 2010, then-Secretary Sebelius established the "Secretary's Tribal Advisory Committee" for HHS to hear directly from tribes on departmental policy development and budget proposals.

What, if any, input would you seek from tribes and urban Indian health organizations about proposed administrative changes to the Medicaid and Medicare programs?

As CMS Administrator, what methods would you employ to ensure proper consultation occurs?

Answer. If confirmed, I will proactively engage stakeholders, including tribes and urban Indian health organizations, on the front-end regarding proposed administrative changes to the Medicaid and Medicare programs. Additional perspective on how CMS policy could impact their beneficiaries and families is of great value to CMS. Communication and collaboration early on in the process ensures that caregivers and families have an opportunity to discuss their priorities, questions or concerns.

Question. In November 2016, the IHS released the outline of its plan to improve care at its facilities. The framework includes 5 priorities—strengthening organizational capacity, maintaining facility accreditation, improving patient experiences, ensuring patient safety, and identifying potential risks earlier.

What role do you see CMS having in these efforts as the framework moves forward?

Answer. If confirmed as Administrator of CMS, I will diligently collaborate and coordinate with all HHS sister agencies, including the Indian Health Service. CMS will continue to conduct Medicare certification surveys for IHS hospitals, and will stand ready to provide technical assistance or other support whenever appropriate.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW AND HON. MICHAEL F. BENNET

Question. The Protecting Access to Medicare Act (PAMA) included requirements that ordering physicians consult appropriate use criteria prior to referring Medicare patients for advanced diagnostic imaging services.

If confirmed, do you intend to implement the appropriate use criteria provisions according to existing statute? Would you start the program on January 1, 2018?

Answer. If confirmed, I will follow the laws as passed by Congress and implement them accordingly. I look forward to closely monitoring challenges associated with this implementation process, while identifying and evaluating specific burdens that have the potential to limit patient access.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

MEDICAID

Question. You have worked extensively on State Medicaid policy and financing issues. In your view, when States face budget shortfalls, what do they typically do to reduce costs in their Medicaid programs, in the absence of additional Federal or State revenue? In other words, what are the "levers" available to States to reduce Medicaid costs? Moreover, which of these levers are most frequently used?

Answer. The current system is inflexible, with States required to receive CMS approval for routine changes. We need to allow States to be innovative and deliver better outcomes while holding States accountable. If confirmed as Administrator of CMS, I will work to allow more flexibility to the States, allowing for innovation in the Medicaid waiver process.

Question. You have stated that Medicaid does not always produce good outcomes for patients. In your view, what specific outcomes—clinical, financial, or otherwise—should States strive for in their Medicaid programs?

Answer. I support State innovations to increase coordination of care, improve access to preventative care, improve drug adherence and lower emergency room usage, all with the goal of improving access to high quality health care and improving patients' outcomes. Outcomes can be measured in a variety of ways but should focus on the patient experience and impact of the program on beneficiaries. I look forward to working with you to reach these goals, if confirmed as Administrator of CMS.

Question. Does the Federal Government have a role to play in encouraging those outcomes, and if so, what is that role?

Answer. We can do better to improve health outcomes. Our goal is to ensure that all Americans have access to high-quality health care with choices that fit their needs and the needs of their family. If confirmed, I look forward to working with you to realize better health outcomes through encouraging innovation, reducing redundant paperwork, and allowing for providers to spend more of their time on their patients while also holding States and providers accountable.

LONG-TERM CARE

Question. Do you support Federal "rebalancing" initiatives, such as the Balancing Incentives and Money Follows the Person programs in the Affordable Care Act?

Answer. I support Americans being in charge of their health care and choosing what works best for themselves and their family. Every State is unique with a different population, different needs and different challenges. If confirmed, I am committed to working to provide States more flexibility to pursue measures that fit the needs of their citizens.

Question. Do you believe that, if well-implemented, "rebalancing" programs such as the Balancing Incentives Program can improve the care experience for patients and reduce State Medicaid costs?

Answer. Every State is unique, and design flexibility is an important component. What works in one State may not work as well in other parts of the country, so if confirmed, I am committed to working to provide States more flexibility to pursue innovative measures that allow States to make the most of available resources and serve their citizens with the highest quality of care.

BASIC HEALTH PROGRAM

Question. The Basic Health Program (section 1331 of the Affordable Care Act) is a State option that is providing health insurance and access to care to more than 750,000 working low-income individuals in New York and Minnesota. States that have taken advantage of this voluntary program are seeing lower costs for beneficiaries, higher enrollment, and net State budget savings, compared to not implementing the program. Through the Basic Health Program, States are price-makers, not price-takers. Do you support the Basic Health Program as a way to empower States to negotiate a better deal on health insurance for their citizens?

Answer. I support State innovation to make the most of available resources and serve their citizens with the highest quality of care. Programs that work well in one State might not translate to other parts of the country. From my experience working with States, I learned that one-size-fits-all solutions won't work so I am committed to increased State innovation and accountability to the citizens they represent.

Question. If confirmed, will you commit to funding and administering the Basic Health Program as required under current Federal law?

Answer. If confirmed, I will follow the laws as passed by Congress and implement them accordingly.

Question. If Congress repeals parts of the Affordable Care Act, will you commit to "not pulling the rug out" from the 750,000 low-income individuals who are benefiting from the Basic Health Program?

Answer. I support Americans being in charge of their health care and choosing what works best for themselves and their family. Our goal is to ensure that all Americans have access to high-quality health care with choices that fit their needs and the needs of their family. I am committed to implementing the law as written and I am committed to implementing it with careful attention to those Americans who may be impacted.

Question. Will you use your administrative discretion as CMS Administrator to not rescind funding for State Basic Health Programs, unless a rescission of that funding is explicitly required by a change to the statute?

Answer. If confirmed as Administrator of CMS, I will follow the laws as passed by Congress and implement them accordingly, including the directions from Congress related to appropriations measures and other sources of funding for health care programs.

DELIVERY SYSTEM REFORM

Question. Washington State and the Pacific Northwest have led the way in pioneering nationally recognized innovations in the delivery of health care—whether it is the Qliance Direct Primary Care medical home model, Group Health Cooperative's highly popular integrated coverage and care model, the Everett Clinic's price transparency initiatives, Boeing's Accountable Care Organizations, or Virginia Mason's team-based care. Despite their innovations, health-care providers in my State are paid nearly $2,000 less (per Medicare enrollee, per year) than the national average, based on CMS spending data compiled by the Kaiser Family Foundation. I would argue that, due to our current volume-based system, my constituents are paid less specifically because they are efficient and because they do a good job of keeping patients healthy. Should the Federal Government reward such high-value health-care providers, as long as we clearly define and agree upon metrics for what constitutes "high-value" care?

Answer. If confirmed as Administrator of CMS, I will follow and implement laws, such as MACRA, related to payment to high-value health-care providers.

Question. Does the current fee-for-service system encourage unnecessary health-care spending? If so, can you please explain specifically how this system encourages unnecessary health-care spending, including in which specialties of medicine, and in which settings of care?

Answer. The current system can encourage unnecessary spending by putting too many health-care decisions in the hands of a distant Federal bureaucracy rather than in the hands of doctors and their patients. All health-care providers, from primary care providers to specialists, should be encouraged to provide value to their patients.

Question. Under the Obama administration, HHS Secretary Burwell and CMS Administrator Slavitt set a goal of providing 50 percent of Medicare fee-for-service spending through alternative payment models. If confirmed, will you continue, rescind, or modify that goal?

Answer. If confirmed, I look forward to reviewing the actions taken by health-care providers and CMS to achieve the initial goal to better understand what has worked and what we can improve upon in the implementation of laws such as MACRA. Additionally, it is crucial to communicate and collaborate with providers and stakeholders throughout the process.

Question. In 2015 Congress passed and President Obama signed into law the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA incorporated the Value-Based Payment Modifier, which I authored in the Affordable Care Act, into Medicare's new physician payment system, the Quality Payment Program. Will you commit to working with Washington State health-care providers to help them succeed in Medicare's Quality Payment Program, as outlined in regulations by CMS, including Advanced Alternative Payment Models?

Answer. If confirmed, I am committed to working closely with the Secretary of HHS to ensure MACRA is implemented fairly and so that it is easy to understand and minimizes burdens, especially on smaller and rural providers.

Question. Will you commit to fund and administer Medicare's Accountable Care Organizations, including the Medicare Shared Savings Program under section 3022 of the Affordable Care Act, and will you commit to helping health-care providers participate in these models, should they choose to do so? Will you commit to not

taking any administrative action that would make it more difficult for Medicare beneficiaries or health-care providers to participate in this voluntary program?

Answer. If confirmed, I will follow the laws set forth by Congress related to Medicare's ACOs, and I intend to work with the Secretary of HHS to ensure, as we move forward, that we learn from the results of ACOs and chart a path forward based on an understanding of what is and what is not working.

Question. Will you commit to fully fund approved grants under the Center for Medicare and Medicaid Innovation (CMMI), and will you continue to fund and administer future payment initiatives under CMMI, consistent with the legislative intent of Congress in the Affordable Care Act?

Answer. I look forward to reviewing current CMMI projects, consistent with congressional actions.

Question. Health-care researchers and providers in Washington State, such as the AIMS Center at the University of Washington and Iora Health, are working to integrate behavioral health services into the primary care experience in order to provide a more seamless care experience, reduce the stigma of behavioral health conditions, and fill historical gaps in access to care. Do you support the integration of primary care and behavioral health into the same care setting?

Answer. If confirmed, to the extent I am not required to recuse from a particular matter under the terms of my Ethics Agreement, I will work to implement the laws passed by Congress. I support flexibility for States to design innovative care programs that improve health outcomes. Both primary and behavioral health care are key components to providing comprehensive care to patients and I support innovative approaches that drive better health care.

SPECIFIC HEALTH CARE LEGISLATION

Question. I have authored bipartisan legislation (S. 2259 in the 114th Congress) to make it easier for rural health-care providers to participate in the Medicare Shared Savings Program by allowing CMS to adopt a broader beneficiary assignment method than is provided under current law. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?

Answer. I am committed to open communication, collaboration, and bipartisanship. If confirmed, I will work with you and be responsive to your inquiries and concerns and provide information on the beneficiary assignment for the Medicare Shared Savings Program.

Question. I have authored bipartisan legislation (S. 2373 in the 114th Congress) to require CMS to cover an essential preventive product, compression therapy items, for Medicare beneficiaries who experience swelling from lymphedema. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?

Answer. I am committed to open communication, collaboration, and bipartisanship. If confirmed, I will work with you and be responsive to your inquiries and concerns and provide information on the Medicare coverage and payment process.

Question. I have cosponsored bipartisan legislation (S. 3129 in the 114th Congress) to preserve patient access to outpatient therapeutic services in Critical Access Hospitals and other rural hospitals. Similar legislation has been signed into law the last 3 years. Will you commit to working with me, my staff, and bill sponsors and cosponsors, on this issue?

Answer. I am committed to open communication, collaboration, and bipartisanship. If confirmed, I will work with you and be responsive to your inquiries and concerns to ensure that critical access hospitals continue to provide quality health care to rural populations.

Question. Will you commit to providing me and my office responsive and accurate technical assistance on any future legislation I author or on which I seek assistance?

Answer. I am committed to open communication, collaboration, and bipartisanship. If confirmed, I will work with you and be responsive to your inquiries and concerns.

WASHINGTON STATE'S SECTION 1115 MEDICAID WAIVER

Question. On January 9, 2017, CMS approved Washington State's proposed Medicaid waiver ("Medicaid Transformation Project, No. 11–W–00304/0) under section

1115(a) of the Social Security Act. In securing agreement on this waiver, Washington State health officials and CMS spent countless hours over more than a year in good-faith negotiations. This approved waiver will help Washington State pursue a smarter and more innovative Medicaid program that reflects changes in health-care delivery, technology, and the preferences of patients. Specifically, the waiver will help my State integrate behavioral health and primary care services, and re-orient the care experience away from higher-cost institutional settings to lower-cost community based settings. Will you commit to honor this approved waiver and not take any administrative action to rescind, weaken, or de-fund its components?

Answer. If confirmed, I am committed to working to provide States more flexibility to pursue innovative waivers that fit the needs of their citizens. Our goal is ensure that all Americans have access to have high quality health care with choices that fit their needs and the needs of their family.

GRADUATE MEDICAL EDUCATION

Question. The vast majority of Washington State counties are Health Professional Shortage Areas (HPSAs) according to HHS's HRSA. In response to an aging population and impending physician shortages, two new medical schools have opened in Washington, each focused on training more physicians to practice in shortage specialties and in medically-underserved communities. Do you agree with an established body of research illustrating that there are physician shortages in the United States, especially in primary care specialties and in rural communities?

Answer. Coverage doesn't always translate to access, and access to care is a critical issue in many areas of our country, especially in our rural areas where there are challenges in attracting workforce. If confirmed, I will work with the Congress, the Secretary of HHS, and the Health Resources and Services Administration (HRSA) to address physician shortages as they relate to Medicare and Medicaid programs.

Question. Given your experience in health-care policy, what is your view of the role the Federal Government should play to promote an adequate and balanced physician workforce in the United States? Or should that role be left to the States?

Answer. When considering new rules and regulations, we all (Federal and State) should be mindful of the workforce shortage, particularly in our rural areas where there are unique challenges in attracting medical providers. We all should proactively engage providers on the front end for valuable feedback and take into account the fact that they may have limited time and resources to implement regulations.

Question. As the practice of medicine transforms, how should Medicare's financial support for graduate medical education (GME) adapt, or should it remain the same?

Answer. If confirmed, I look forward to working with you and other members of Congress on your priorities to see that our GME programs work well for a 21st-century medical work force.

MEDICARE REIMBURSEMENT

Question. CMS recently finalized a regulation implementing section 603 of the Bipartisan Budget Act, which effectively reduces Medicare payment rates for certain newly established, off-campus hospital outpatient departments to the payment level under the physician fee schedule or ambulatory surgery center fee schedule. If confirmed, how will you approach implementation and interpretation of section 603 of the Bipartisan Budget Act?

What exceptions, if any, are appropriate to "site-neutral" payment reductions?

Do you support "site-neutral" payment policies in Medicare? If you do in part, could you explain in what settings they are appropriate, and in what settings they are not?

Answer. If confirmed, I will support the implementation of the site-neutral payment rules that Congress has enacted or will enact. Ensuring that patients can access quality care in all kinds of health-care settings is a priority for Congress, CMS and the American people. It is essential that beneficiaries have robust choices in their providers and I look forward to implementing policies that ensure we attract providers to deliver quality care.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. On January 30th, President Trump issued an executive order that requires some Federal agencies to repeal two regulations for every new one issued. Given the sheer number of rules and regulations that CMS must issue every year, how do you envision this executive order functioning so that CMS can continue to do its job? Can you give me examples of two specific regulations that you would repeal as CMS Administrator?

Answer. If confirmed as Administrator of CMS, I look forward to reviewing existing regulations and any new proposed regulations to determine applicability to the President's Executive order.

Question. Over 4 million seniors in Florida rely on the health and financial security provided by the Medicare program. I've consistently opposed efforts to convert Medicare to voucher program, which would fundamentally change the program and leave seniors exposed to higher out-of-pocket costs. How would you propose to help people on Medicare and their families with the rising cost of medical care and long-term care?

Answer. I support offering choices for seniors and opportunities for additional benefits. Ultimately, the direction of Medicare is up to Congress and if confirmed as Administrator of CMS, I will follow the laws as passed by Congress and implement them accordingly. I hope we can work together to make the program more sustainable.

Question. Then-Congressman Price introduced a bill (the Medicare Patient Empowerment Act) to allow practitioners to enter into private contracts with their Medicare patients and charge higher fees than what is currently allowed under the Medicare program. Currently, when seniors in Medicare see their doctors they are responsible for a set amount of costs and physicians participating in Medicare cannot bill their patients for any outstanding costs. Do you support this change in policy?

Answer. I support offering choices for seniors and putting Americans in charge of their health care and choosing what works best for them and their family. Medicare policy-making is in large part done by Congress, so I look forward to working with you on Medicare issues.

Question. The ACA includes provisions designed to improve treatments for people with substance use disorders, including opioid addiction. It included mental health and substance use disorder treatment as essential health benefits; it expanded access to treatment services; it eliminated lifetime limits on behavioral health services; and ended discrimination by insurers based upon pre-existing conditions.

According to the CBPP, 1.3 million people with serious mental illness and 2.8 million people with substance use disorders would lose health coverage under ACA repeal. Would you recommend that President Trump and congressional Republicans maintain the provisions listed above in any replacement plan? Beyond keeping the ban on discriminating against people with pre-existing conditions, what are the elements that any replacement plan must include?

Answer. My goal is to ensure that all Americans have access to high quality health care with choices that fit their needs and the needs of their family. If confirmed, I will follow the laws as passed by Congress and implement them accordingly.

Question. As CMS Administrator, what administrative actions would you take to address the opioid epidemic?

Answer. If confirmed as Administrator of CMS, to the extent I am not required to recuse from a particular matter under the terms of my Ethics agreement, I will work closely with the Secretary and the Substance Abuse and Mental Health Services Administration (SAMHSA) whose duty is to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities. It is critical that all Americans suffering from mental health and substance abuse disorders have access to the care they need.

Question. The Medicare Advantage program is an affordable option offering out-of-pocket spending caps, additional benefits like vision and dental, and often prescription drug coverage at no additional cost for many of my constituents. As Administrator, what specific actions would you take to strengthen and build upon this vital part of the Medicare program? How will you ensure that the 1.6 million seniors in Florida, and the 18 million that enrolled across the Nation are protected?

Answer. I am committed to preserving and strengthening the Medicare Advantage program as it offers additional benefits and provides additional choices to seniors. If confirmed, I look forward to working with you and other members of Congress to support the program.

Question. A CMS Medicare Graduate Medical Education (GME) rule prevents a number of hospitals that hosted—for a very brief period of time—medical residents from another facility's teaching program from establishing their own full-time Medicare support residency programs. Under current CMS policy, hospitals considered by CMS as "new" teaching hospitals are permitted to establish a permanent full-time (FTE) resident cap and per resident amount (PRA), which allows for reimbursement by CMS for Medicare's share of the hospital's training costs. I have heard from a small number of community hospitals in my State that inadvertently triggered a very low resident and/or PRA though hosting resident rotators for short periods of time. Do you commit to working with me to fix this glitch? Does CMS have the authority to fix this problem without congressional action?

Answer. If confirmed, I commit to looking into this issue with you and helping you evaluate the options at both the legislative and executive level.

Question. In 2016, CMS announced a new pre-claim review demonstration (PCRD) for home health services in five States. The demonstration began in Illinois in August, with plans to expand to Florida, Texas, Michigan and Massachusetts. Because of problems experienced by beneficiaries and providers in Illinois, program expansion was delayed. It is now scheduled to be implemented in Florida on April 1st, without any changes. Do you plan to continue this demonstration in Illinois? Do you plan to move forward with the demonstration in Florida? If so, will you amend the scale of the demonstration and provide additional safeguards for providers?

Answer. If confirmed, I would review current demonstrations as well as the results of other similar demonstrations to understand the challenges and any lessons learned that may be applied to the Pre-Claims Review Demonstration. I look forward to working with you to address your concerns.

Question. When the Medicaid program was created in 1965, there were fewer service delivery settings and options available for consumers. As a result, nursing home care was made a mandatory benefit within the program. Since then, service innovations and technologies have enabled care to be safely and effectively delivered in home and community-based settings, yet the Medicaid program still retains the mandate for nursing home placement. States must seek a waiver in order to enable consumers to receive home and community-based care. How do you intend to use administrative power to facilitate beneficiaries have access to high-quality, cost-effective home and community-based services? How would cuts to State Medicaid programs through block grants and per capita caps impact the ability of States to deliver high quality home and community-based services to an aging baby boomer population that wants to receive long-term services and supports at home and in their communities?

Answer. I support Americans being in charge of their health care and choosing what works best for themselves and their family. Every State is unique with a different population and different needs and the Medicaid program should be more flexible to address the changing health-care landscape and population needs with the goal of improving health outcomes. If confirmed, I am committed to working with States, in accordance with the laws passed by Congress, to provide more flexibility to pursue innovative measures that fit the needs of their citizens. At the same time, States must be held accountable to standards that result in better health-care quality and access. Our goal is to ensure that all Americans have access to high quality health care with choices that fit their needs and the needs of their family.

QUESTIONS SUBMITTED BY HON. BILL NELSON AND HON. ROBERT MENENDEZ

Question. Puerto Rico's economic recession has caused the number of Puerto Rico residents migrating to the States to reach staggering levels. The situation is made worse by physician shortages, a Medicaid program facing chronic funding shortfalls, and across-the-board disparities in Federal health programs.

Puerto Rico's Medicaid program serves about 1.4 million residents—over 40 percent of the island's population. The Affordable Care Act provided Puerto Rico with a one-time funding boost of $6.4 billion set to expire at the end of fiscal year 2019.

This funding will be depleted in 2017. Once this money is gone, Puerto Rico will go back to receiving its annual set Medicaid allotment, about $350 million in FY 2018.

Do you believe Puerto Rico should be treated the same as States under Federal Medicaid laws?

Answer. As you acknowledge in your question, Puerto Rico's fiscal challenges are much broader than those pertaining to their Medicaid program. It is my hope that leaders in the Commonwealth and in Congress will be able to adequately fund Puerto Rico's Medicaid program while addressing their overall fiscal situation. If confirmed, I will follow the laws as passed by Congress and implement the law accordingly.

Question. Do you support extending the Medicare Part D LIS program to seniors residing in Puerto Rico and the other territories? If you do not believe low-income seniors in Puerto Rico should have access to the LIS program, why?

Answer. Extending the Medicare Part D LIS program to seniors residing in Puerto Rico and other territories would require a change in statute. Therefore, this is a legislative matter and I defer to Congress to address this issue. I will faithfully administer the Medicare Part D program as written in statute.

Question. In order to use their supplemental allotment, the Puerto Rico Government must pay a 45 percent local match. During the last 3 years, the Puerto Rico Government drew down only half of its Federal allotment funds because it could not generate its match. Do you believe CMS should remove or waive the local matching requirement so that Puerto Rico can fully access the allotment funding? If you do not believe this matching requirement should not be waived, why?

Answer. Access to quality health care for the people of Puerto Rico is an important issue that I look forward to working with Congress and the Commonwealth to appropriately address in accordance with the law. Puerto Rico's broader economic challenges impact the Commonwealth's health care financing capabilities, so I am hopeful that these issues can be addressed in order to make Puerto Rico fiscally sound and healthy.

Question. Last year, we had the honor of serving on the bipartisan, bicameral congressional Task Force on Economic Growth in Puerto Rico. The Task Force was responsible for identifying steps to help stabilize and grow Puerto Rico's economy. The Task Force recommended that Congress enact fiscally-responsible legislation to address the Medicaid cliff established by the ACA. Will you commit to taking up the Task Force's recommendation to ensure that going forward Federal financing of the Medicaid program in Puerto Rico should be more closely tied to the size and needs of the territory's low-income population? What specific actions would you take to help achieve this goal?

Answer. I look forward to reviewing the Task Force's recommendations and implementing the laws as designed by Congress related to the financing of Puerto Rico's Medicaid program.

Question. Will you commit to enacting the Task Force's recommendation that CMS undertake any additional administrative steps necessary to ensure that Medicare Advantage plans in Puerto Rico are being fairly and properly compensated for the services they provide to beneficiaries? What specific administrative steps will you recommend CMS take?

Answer. Every effort should be made to ensure that Medicare Advantage plans in Puerto Rico are being fairly and properly compensated for the services they provide. If confirmed, I will carefully study and consider the Task Force's recommendations, and work closely with members of Congress in order to determine how best to proceed on this important matter.

Question. The Obama administration established a working group that included HHS and CMS officials and Puerto Rico health-care stakeholders to jointly propose solutions to the ways in which the funding crisis is manifested. This includes, among other critical policies, dealing with the statutory cap on Medicaid expenditures and the lack of a low-income drug subsidy. Do you commit to ensuring CMS continues its focused and meaningful participation in this working group to ensure that we address Puerto Rico's disparate treatment under Federal health programs?

Answer. I commit to working with you and all parties involved to ensure that the people of Puerto Rico are able to access high quality health-care plans and receive

the proper attention of CMS as we evaluate our options and provide technical assistance for legislative matters as appropriate.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

RECUSAL FROM MENTAL HEALTH ISSUES

Question. In the hearing I asked you a question about the ACA's Essential Health Benefit package as it pertains to coverage of behavioral health services, specifically for autism services. In your response you mentioned that you were recusing yourself from mental health policy in light of your husband's work as a psychiatrist.

According to your letter to the Associate General Counsel for Ethics at the Department of Health and Human Services, you say that you "will not participate personally and substantially in any particular matter that to (your) knowledge has a direct and predictable effect on the financial interest of the Indian Health Group" at which your husband practices.

Can you provide more detail about exactly what you plan to recuse yourself from, if confirmed?

Answer. As noted in my Ethics Agreement, which you reference above, because of my husband's practice as a psychiatrist with the Indiana Health Group, Indianapolis, IN, and his financial interest in the Indiana Health Group, I have agreed not to participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the Indiana Health Group, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). Under the Federal ethics regulations, I am not required to recuse from consideration or adoption of broad policy options that are directed to a large and diverse group of persons. I will be required to recuse from matters that involve deliberation, decision or action that is focused upon the interests of the Indiana Health Group, or the discrete and identifiable class of persons or entities that includes the Indiana Health Group. To the extent that I have questions on how to apply my recusal obligations to a particular matter, I will consult with the HHS Ethics Office for guidance on the scope of my recusal obligations.

Question. Does this recusal include your work on any/all work to oversee and enforce Federal mental health parity laws?

Answer. Although I will consult with the HHS Ethics Office as needed for guidance, the mental health parity rules are focused on insurance coverage for mental health services and/or substance use disorder services, these rules may impact entities such as the Indiana Health Group and service providers in the Group, including my husband, that receive insurance reimbursement for mental health and substance use disorder services. Accordingly, I will recuse from this work.

Question. Will you recuse yourself from dealing with any Medicaid waiver applications that include mental health components, such as the Comprehensive 1115 Waiver in New Jersey which is largely about the ID/DD population?

This is of particular importance given the massive changes to the Medicaid program you have previously championed and will, presumably, continue promoting. Seeing as the Indiana Health Group refuses to treat individuals enrolled in Medicare, Medicaid and CHIP, can you confirm your recusal from these issues?

Answer. The 1115 Medicaid Waiver application for New Jersey is a particular matter involving New Jersey as a specific party. Resolution of that waiver will be State-specific. Accordingly, under the ethics regulations, my ethics obligation will not require my recusal from this waiver.

Question. Since my question during the hearing was actually about insurance benefit design generally, not about anything specific to do with payment to providers of any kind, can you clarify your views on whether or not a child's access to insurance coverage (not only for behavioral health and autism services, but any health service) should be based on the State in which they live?

Answer. Children are some of our most vulnerable citizens and I support ensuring that they receive quality health care through the most effective means available.

MEDICARE PACKAGED PAYMENT POLICIES

Question. As you may be aware, Medicare Part B hospital and ambulatory surgery center payments account for medications which cost more than a nominal amount

to be reimbursed "at cost" rather than getting "packaged" into the procedure code payment. This is because, according to CMS, because packaging certain types of drugs "might result in inadequate payments to hospitals, which could adversely affect Medicare beneficiary access to medically necessary services."

However, in recent years, CMS seemed to forget this rationale and finalized a series of rules to package certain "drugs that function as a supply when used in a surgical procedure" and that "function as a supply in a diagnostic procedure." This package payment policy, which has nothing to do with the actual price of the drug or the amount Medicare pays for the drug, has made several critical treatment options out of reach for beneficiaries due to the sharp decrease in reimbursement resulting from the packaging policy.

If confirmed as Administrator, will you commit to revisiting this policy in the upcoming rulemaking cycle and conduct an in-depth evaluation of the impact this packaging payment policy has had on beneficiary access to the services the current regulations single-out for packaged reimbursement?

Additionally, if this evaluation demonstrates decreased access to care for Medicare beneficiaries or an increased burden on providers that make providing these services more difficult, will you commit to make changes to ensure access is restored?

Answer. If confirmed, I commit to thoroughly reviewing the rules to ensure they are implemented consistently with the law and with the utmost regard for the accessibility of high quality health care for all impacted Medicare beneficiaries.

PROPER OVERSIGHT OF MEDICARE CONTRACTORS

Question. As you might know, CMS contracts out several administrative activities, such as processing Fee for Service claims, medical record review, provider enrollment and the establishment of local coverage determinations (LCDs), to Medicare Administrative Contractors (MACs). MACs are divided up by region and serve as the agency's primary contact agent with Medicare providers. It has recently come to my attention that the MAC covering New Jersey is implementing a prior-authorization requirement for certain services, specifically hyperbaric oxygen therapy (HOBT). While I generally support the idea of prior-authorization in certain cases, the New Jersey MAC has issued an LCD, and further guidance on its website through a Frequently Asked Questions page, that is having a significant impact on beneficiaries' ability to receive this important therapy and that contradicts well-established medical and scientific practices. Additionally, it appears that the MAC is implementing this prior-authorization differently in New Jersey than other MACs in other States, causing provider confusion and unequal access to care across the country.

If confirmed as Administrator, will you work to provide the necessary oversight of MACs and other contractors to ensure the policies they implement are both consistent across the country and consistent with medical best practices?

Answer. I will strive to do so. If confirmed, I would be pleased to work with you on this issue. Our goal is to offer seniors access to the care they need. I appreciate the need to engage in oversight to identify and evaluate challenges associated with MACs and LCDs more generally.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Question. Since 1997, the Children's Health Insurance Program (CHIP) has been essential for children and pregnant women in working families who cannot afford private health insurance. Today, CHIP provides affordable health coverage to over 8 million children and hundreds of thousands of pregnant women across the country. Taken together, CHIP and Medicaid have combined to reduce the number of low-income, uninsured children across the country by half. At the same time, the program has improved health outcomes and access to care.

As was mentioned during your hearing, the CHIP program needs to be reauthorized by Congress this year, and now-Secretary Tom Price stated that he supported an extension of up to 8 years.

If confirmed as Administrator, will you commit to working with Congress to enact a long-term reauthorization of the CHIP program and to do so in a manner that maintains the program's success at providing comprehensive coverage to pregnant women and children and does not limit funding, coverage, access or quality?

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

plays a major role in this, but there is also a need to focus on family coverage in the private market and employer plans, and on giving States needed flexibility. Each State has different needs, and I believe CMS needs to work with States to ensure that, consistent with those needs, the CHIP program provide possible coverage to their residents. If confirmed, I would work with Congress on CHIP reauthorization with these principles in mind.

HOME VISITING PROGRAMS

Question. As you may know, evidence-based home visiting programs, working in conjunction with FQHCs, promote support and expand access to children and families, specifically those eligible for, or enrolled in, Medicaid. One such program is the Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program. In 2015 alone, MIECHV provided services to nearly 150,000 parents and children in more than 800 counties in all 50 States, all five territories, and the District of Columbia. However, coordination between MIECHV grantees and Medicaid is often difficult given that Medicaid is the payer of last resort in all cases except those with a specific exemption in law, such as what exists under the Maternal and Child Health Services Block Grant, Special Supplemental Nutrition Program for Women, Infants and Children and services provided as part of an Individualized Education Program or Individualized Family Service plan under the IDEA. Currently, MIECHV services do not have that explicit exemption, despite being focused on maternal and child health as the other exempted programs are. There has been no effort on the part of CMS to meaningfully address the issue of benefit coordination, causing confusion among service providers and impeding access for beneficiaries.

If confirmed as Administrator, will you commit to clarifying the funding relationship between the MIECHV and Medicaid programs?

Answer. If confirmed, I commit to working with you to better understand this relationship and to evaluate all options to address MIECHV and Medicaid issues at both the legislative and executive level with the goal of improving the health and well-being of mothers and their children.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ, HON. SHERROD BROWN, HON. RON WYDEN, HON. MICHAEL F. BENNET, AND HON. ROBERT P. CASEY, JR.

Question. Congress passed the Protecting Access to Medicare Act (PAMA) in 2014. This bipartisan law included policies to update and change the way Medicare reimburses clinical laboratories under the Clinical Laboratory Fee Schedule (CLFS), moving the reimbursements towards a market-based payment methodology. Under the law, all "applicable" laboratories are required to report to CMS the payment rates and test volumes for their private payers.

CMS finalized PAMA regulations in June 2016, and released further guidance in September 2016, which impose an unrealistic reporting timeline for laboratories. Additionally, we have heard from our regional and community-based laboratories about significant concerns they have about their ability to report accurate data and how the current rules' exclusion of market data from hospital outreach labs and definition of "applicable laboratory" will impact the accuracy of CMS's data.

If confirmed, will you commit to looking at the current PAMA regulations and reporting requirements to ensure that independent, physician and hospital laboratories are appropriately and accurately accounted for in the market price data?

Answer. I appreciate your concerns regarding the implementation of PAMA. Certainly, we should strive for accuracy in this market data collection process. It is important that patients have access to community-based labs. Accordingly, I look forward to closely monitoring challenges associated with this implementation process, while identifying and evaluating specific burdens that have the potential to limit patient access.

Question. Further, will you commit to evaluating the need to extend the March 31, 2017, reporting deadline to ensure that laboratories—especially smaller, community laboratories—are able to successfully collect and report the data required under the regulations?

Answer. I look forward to following up with CMS staff and regional and community-based laboratories to discuss workable solutions.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

EXPERIENCE WITH PRIVATE HEALTH INSURANCE MARKETS

Question. As you know, the House and the Senate recently passed budget resolutions to repeal the Affordable Care Act and cut Medicaid funding by more than $1 trillion. More than 20 million Americans gained health insurance as a result of the Affordable Care Act. Can you share your experience and background working with the individual and small group health insurance markets? If confirmed as Administrator of the Centers of Medicare and Medicaid Services (CMS), what specific actions will you take to "fix" our State insurance markets and ensure access to health insurance for the millions of Americans who gained coverage under the ACA?

Answer. I worked with States in preparing for the changes brought about by the ACA including working with State insurance departments and reviewing and implementing ACA regulations. If confirmed as CMS Administrator, I will work to ensure that every State insurance commissioner has as much flexibility as possible to repair their respective insurance markets.

MEDICARE

Question. Ms. Verma, you noted in your testimony that the American people are tired of politics and just want their health-care system fixed. As you already know, we recently passed bipartisan legislation to reform the way Medicare reimburses physicians, moving from a fee-for-service system to payment based on better quality and improved outcomes. In your experience, what kinds of reimbursement systems do you believe are best suited to improving health outcomes and driving down costs? In your opinion, what are the strengths and weaknesses of accountable care organizations, bundled payments, and patient-centered medical homes? What other types of payment reforms should be implemented in Medicare to improve the quality of health care while reducing unnecessary costs?

Answer. We share the goal of improving Medicare by empowering providers to be creative and developing payment models that best suit the unique needs of their patients to ultimately improve patient care. For instance, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) establishes the Physician-Focused Payment Model Technical Advisory Committee to review proposals for physician-focused payment models that can ultimately be adopted by CMS. More generally, a fundamental principle for payment reforms is the centrality of the patient in the system and their ability to make choices about their care in consultation with their doctor and that we drive toward better coordination and improving quality and health outcomes.

MEDICAID

Question. In the Healthy Indiana program, you strongly promoted the use of personal responsibility such as the use of co-pays and cost-sharing for Medicaid beneficiaries. For some extremely poor Medicaid beneficiaries, the premiums and co-pays are just $1, which does not seem unreasonable. When one of these beneficiaries fails to pay their $1 premium, how much does Indiana spend to collect this bad debt? Do beneficiaries with no income through no fault of their own, for example if their employer goes out of business, still have to pay premiums for their Medicaid benefits? When Medicaid beneficiaries lose their Medicaid benefits because of their inability to pay their premiums and goes to the hospital emergency room for care, what does it cost Indiana and American taxpayers? Does Indiana's Medicaid program fully recoup the dollars spent on managing this program?

Answer. The Healthy Indiana Plan's contribution requirements are not designed as a punitive measure but as a way to promote personal responsibility in members which has resulted in better health outcomes, including lower ER use, higher patient satisfaction, drug adherence and more primary and preventative care. Only members above the poverty line are at risk of losing coverage for non-payment. Where HIP members are locked out of coverage for 6 months for non-payment, those who fail to pay Marketplace premiums may have to wait until the next open enrollment period to regain coverage, which can be up to 9 months, unless they have a change in circumstance that makes them eligible for a special enrollment period. On the whole, HIP's non-payment policies for individuals above the poverty line are at least comparable, if not more lenient, than the policies governing the Marketplace. Moreover, only 5 percent of former HIP members indicated they left the program due to affordability issues. Additionally, more than 80% of HIP members have indicated they would be willing to pay *more* to stay in the program, while more than

half of those who left the program due to non-payment successfully transitioned to private health insurance coverage.

OBESITY

Question. We know that the disease of obesity costs the health-care system hundreds of billions of dollars a year in needless and potentially unnecessary treatments. The States you have worked with, such as Indiana, Kentucky, Tennessee and Iowa, have some of the highest rates of obesity in the country. It is long past the time that CMS adopt an "all-in" approach to fighting obesity. As CMS Administrator, how will you seek to maximize current obesity treatment programs and increase the treatments available to overweight or obese patients? Specifically, how would you increase access to nutritional counseling for overweight and obese individuals in the Medicare and Medicaid programs?

Answer. Obesity is a chronic condition, and I agree that it is an important priority for our health-care system to address this condition for both children and adults. We need to strengthen the relationship between patient and doctor in order to address this disease on the front end and support providers in identifying best practices as well as supplying technical assistance as providers address this critical issue.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Question. In Medicare, Medicaid, and the private sector, we are seeing significant and accelerating change towards value-based care and reimbursement based on better quality and outcomes. Yet the Program of All-Inclusive Care for the Elderly (or PACE), which pioneered so many of the features we now seek to build into our health-care system, is being constrained by outdated regulations. If confirmed, what will do you do to ensure that CMS updates these regulations quickly to provide more flexibility to PACE and to expand access to this program for medically frail seniors?

Answer. I look forward to reviewing the regulations currently in place and changes outlined in the proposed rule and working with Congress to eliminate any regulations that hinder efficiency or access to quality care.

Question. It is important for CMS to issue a final rule that would update and improve the Program of All-Inclusive Care for the Elderly (PACE). A proposed rule to update PACE was issued in August 2016 to increase access to care, remove inefficiencies in the system and assure continuous care to many of the most vulnerable patients. An important change in the proposed rule would explicitly allow physician assistants (PAs) to be employees or contracted providers for PACE programs. While PAs currently provide high quality medical care and chronic care management to Medicare and Medicaid beneficiaries throughout the country, current CMS rules exclude PAs from being an employee or contracted provider in the PACE program. Will you continue work to strengthen the PACE program and ensure it is modernized in a way that effectively uses PAs and other health-care providers, who provide high quality, affordable health-care services?

Answer. I look forward to reviewing the changes outlined in the proposed rule, and I agree that PAs are a vital part of our health-care system and should be used to provide high quality, affordable health-care services.

IMPROVING THE VALUE OF HEALTH CARE

Question. Improving the value of health care has been a shared bipartisan priority for several decades, as the share of our economy dedicated to health care has continued to rise, but not necessarily in sync with the overall quality of health care and health outcomes. Implementation of the quality reporting and performance programs is an important tool for increasing the quality of health care, improving health outcomes and lower unnecessary costs. How will you advance health care quality reporting and value-based purchasing programs in Medicare, Medicaid, and in private health insurance plans?

Answer. I look forward to reviewing our current quality reporting and performance programs to ensure that they provide the data needed to improve patient outcomes while not becoming so burdensome that they reduce providers' ability to give quality care. Ensuring transparency so that patients can make informed decisions about the care they receive is a crucial component of this and I look forward to working with Congress on this issue.

HEALTH-CARE COSTS AND QUALITY

Question. The United States spends nearly twice as much on health care as other developed countries, such as Japan, but fails to provide insurance coverage for all Americans. Health outcomes and quality, such as infant mortality, preventive care, and overall lifespans, often lag behind other countries as well. What are three specific health-care programs or public health strategies utilized by other countries' health-care systems that you would seek to emulate in the Medicare, Medicaid, and private health insurance programs and how would you adapt them to fit demographic trends, cultural norms, and logistical challenges unique to the United States.

Answer. The United States is a world leader in medical research and medical innovation and performs well in key health indicators, such as cancer survival rates. We should focus on how we can provide access to quality health care for all Americans with local solutions that work best for individual patients and their families. Data-driven decisions based on price and quality transparency should be afforded to American patients as we learn from other countries and their efforts in those areas.

AFFORDABILITY

Question. For many Americans, the affordability of health insurance continues to be a significant barrier to accessing basic health care. How would you seek to increase the affordability of health insurance, lower insurance premiums, and reduce deductibles and co-pays, while also ensuring that all Americans have comprehensive, high quality, and dependable health insurance plans? Do you think that health insurance plans should be able to apply annual and lifetime limits on health insurance coverage?

Answer. As this is a matter for Congress, I look forward to working with Congress to make sure that every American has access to affordable health care.

FEDERALLY-QUALIFIED HEALTH CENTERS

Question. Federally-qualified health centers (FQHCs) play fundamental roles in communities across the United States providing individuals and families with access to high quality health care who might otherwise find access to health care to be unaffordable. How will you work to protect reimbursement rates to FQHCs in Medicare, Medicaid, and private health insurance plans? How will you work to increase the number of FQHCs throughout the country?

Answer. I look forward to working with Congress to implement reimbursement policies that expand health-care access to all Americans in a wide range of health-care settings, including FQHCs, which play an important role in our health care safety net.

CONTRACEPTION

Question. Do you believe that all women should have access to all forms of contraception and family planning services without additional cost? How would you seek to expand access to and increase utilization of contraception for all women and their families in the United States?

Answer. Women should have the health care that they need and want. As we work to replace the ACA, we should build on a system that gives women affordable options, not mandates, and puts women at the center of their own health care.

QUESTION SUBMITTED BY HON. THOMAS R. CARPER AND HON. ROBERT P. CASEY, JR.

NUTRITION AND MALNUTRITION

Question. Improving nutrition and lowering malnutrition are two areas that do not receive sufficient attention in Medicare, Medicaid, and private health insurance quality reporting programs. For example, even though there are many quality measures in place for other health conditions, there are no measures in place relating to malnutrition. How do you view the role of nutrition in improving health care, and how do we prioritize nutrition and malnutrition care as low cost solutions in improving clinical health outcomes? Do you believe that nutrition/malnutrition care should

be part of the quality reporting and performance programs for Medicare, Medicaid, and private health insurance plans?

Answer. I agree that nutrition is an important part of overall health, and I look forward to reviewing current reporting and performance programs for Medicare, Medicaid, and private health insurance plans to make sure that we get the data we need to improve health outcomes and to understand the impact of determinants of health, such as nutrition.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

CENTER ON MEDICARE AND MEDICAID INNOVATION (CMMI)

Question. Do you support continuing the work of the Center on Medicare and Medicaid Innovation (CMMI) to identify alternative payment models (APMs) which achieve savings and improve quality of care?

Will you allow CMMI to continue implementing the various demonstration projects currently underway and expand them if they prove successful at reducing costs without harming quality of care?

Answer. I support innovation in whatever format it can be encouraged in accordance with the law. I also believe that we should work in partnership with the States and that CMMI demonstration projects should be carefully considered on criteria involving their scale and the voluntary nature of the respective demonstration. I look forward to reviewing current CMMI projects, consistent with congressional actions.

CHILDREN'S HEALTH COVERAGE IN MEDICAID

Question. Medicaid is one of the largest and most important components of the Nation's health care safety net, offering a pathway to health coverage for low-income and medically vulnerable Americans. In my home State of Maryland, over 478,000 children receive essential health care through the program. That's one in three children in my State who can see a provider when they are sick and get the preventive health screenings they need to stay healthy.

I am particularly concerned about the impact of a Medicaid block grant or per capita cap on the program's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, under which children enrolled in the program receive both regular wellness visits, preventive services, and coverage for all medically necessary treatments, for example pediatric dental care, that a child needs. In FY 2014, over 40 million children nationwide were eligible for EPSDT benefits. In Maryland, over 705,500 children were eligible for EPSDT benefits in 2015—more than 171,000 of whom became eligible through the Patient Protection and Affordable Care Act's Children's Health Insurance Program (CHIP)—Medicaid expansion.

Experts contend that if Medicaid expansion is repealed, States would no longer be required to provide coverage of this comprehensive benefit for children, and/or could eliminate the requirement that EPSDT services be provided without a copayment.

If confirmed as CMS Administrator, do you commit to ensuring the Medicaid EPSDT benefit and coverage for vital pediatric services remain intact for the millions of children who rely on it?

Answer. Our goal is to ensure every single American has access to the coverage they want for themselves or their children and dependents, and children are, and will continue to be, a high-priority population within the Medicaid program. States are well-positioned to determine the most appropriate ways to ensure access to the highest quality care for children, which may include diagnosis and screening procedures and the illnesses and conditions they uncover. As this is a matter for Congress, I look forward to working with Congress to improve our Medicaid system.

EMERGENCY HEALTH SERVICES

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

vidual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.

Do you support this Federal policy?

Will you ensure the Centers for Medicare and Medicaid Services continues to enforce the prudent layperson standard for all Medicaid MCOs?

Answer. If confirmed, it would be my duty to implement the law as passed by Congress.

KIDNEY CARE

Question. The 2011 revisions of the end-stage renal disease (ESRD) payment system stressed the importance of protecting access to all treatment modalities and transplant for dialysis patients in the Medicare program. I share the concerns of many dialysis patients in my State, that efforts to repeal or replace the Patient Protection and Affordable Care Act will limit access to the modality of their choice or the full scope of transplant options.

In recent years, CMS has reduced the in-center dialysis payment rate to increase an add-on for home dialysis training. I support the ability of ESRD patients to successfully manage their disease at home and while it may be appropriate to increase the rate for training home dialysis patients, we must find a way to ensure that individuals who require care at dialysis centers are able to do so.

What will your approach be to protecting access to all dialysis modalities, as well as transplantation?

Answer. As this is a matter for Congress, I look forward to working with Congress to make sure that patients with renal disease have access to high quality, affordable treatment.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN AND HON. BILL NELSON

Question. The 21st Century Cures Act, which was recently enacted into law, includes a provision I authored with Senators Crapo and Nelson, which requires Medicare Advantage (MA) plans to accept individuals with end-stage renal disease (ESRD). Federal law concerning when Medicare Supplemental Insurance carriers (Medigap) must be offered to individuals, does not require insurers to offer plans to people under the age of 65, including those with ESRD (although some States do require this).

Do you believe that Medigap coverage should similarly be extended to those under the age of 65, including individuals with ESRD?

Answer. As this is a matter for Congress, if confirmed, I will implement the laws passed by Congress and I look forward to providing any technical assistance which might be needed as Congress considers reforms.

MEDICARE

Question. People under the age of 65 with disabilities generally have a 2-year waiting period from when they first start receiving Social Security Disability Insurance (SSDI) before they are eligible for Medicare coverage. The Patient Protection and Affordable Care Act (ACA) provided an important protection for people in this waiting period who otherwise could not obtain coverage. If the ACA is repealed, do you think these individuals should be forced to again fend for themselves until Medicare coverage kicks in?

Answer. As this is a matter for Congress, if confirmed, I will implement the law as passed by Congress.

NOTICE ACT

Question. With our growing, aging population, Medicare must evolve to meet the country's most pressing health-care demands. One issue we've started to address is hospital observation status for Medicare beneficiaries. Often, Medicare beneficiaries who receive care in hospitals, even for several days, may be surprised to learn that they have not actually been admitted as inpatients. Instead, these patients are classified as "observation status" or outpatients.

Observation status is particularly concerning for Medicare beneficiaries who may require skilled nursing facility (SNF) care after being discharged from the hospital. Currently, Medicare only covers SNF care for patients who have a 3-day inpatient hospital stay.

Do you believe that seniors deserve to know when their hospital care is classified as "observation status"?

Answer. If confirmed, I look forward to working with Congress to ensure that seniors have the information available to make the best decisions about their care, including CMS's implementation of the NOTICE Act, which requires hospitals to notify patients of their observation status.

Question. Last Congress, my colleague Senator Enzi and I introduced the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which became law in December 2015. This legislation requires hospitals to give each Medicare patient who receives observation services as an outpatient for more than 24 hours an adequate oral and written notification within 36 hours.

In December 2016, CMS finalized the NOTICE Act rule requiring hospitals to give patients the standardized Medicare Outpatient Observation Notice (MOON) beginning March 8, 2017. CMS anticipates that more than 1 million patients will receive the MOON annually.

Will you commit to implementing this final rule to ensure that seniors are able to make informed health-care decisions?

Answer. If confirmed, I look forward to reviewing that rule to make sure that CMS acts in accordance with Federal law and to working with you on any concerns you may have.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN AND HON. DEBBIE STABENOW

ORAL HEALTH

Question. Oral health and related illnesses have a significant impact on the severity of chronic diseases, which are the most burdensome for older people and people with disabilities, and costly for the Federal Government. The serious health risks and costs associated with untreated oral disease are increasingly apparent. For example, because they heighten the risk of systemic infection, unresolved oral health problems can preclude, delay, and even jeopardize the outcome of medical treatments such as organ and stem cell transplantation, heart valve repair or replacement, cancer chemotherapies, and placement of orthopedic prostheses. The relationship between periodontal disease and chronic conditions such as diabetes, arthritis, and heart disease is also well established.

While Medicare statue precludes coverage of "routine" dental services, would you agree that untreated oral health problems, in these examples at least, would be medically necessary rather than "routine"?

Answer. If confirmed, I will review what services have been classified as "routine" and what services have not.

Question. Are you committed to using your authority as the CMS Administrator to ensure that Medicare covers medically necessary oral health care, as currently allowed by the statute?

Answer. If confirmed, it will be my duty to follow Federal law including the implementation of laws related to Medicare Advantage plans which can provide quality oral health care.

Question. Will you commit to evaluating proposals to expand oral health coverage for Medicare beneficiaries more broadly?

Answer. I would be happy to evaluate any proposal that will lead to affordable, high quality health care.

QUESTIONS SUBMITTED BY HON BENJAMIN L. CARDIN AND HON. THOMAS R. CARPER

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Question. Johns Hopkins has been on the forefront of innovative care for the most fragile and complex individuals. The Program for All-inclusive Care for the Elderly (PACE) is widely recognized as the gold standard for fully-integrated, comprehensive care. Researchers have shown that the community-based, comprehensive and accountable care offered by PACE delivers quality care, improved health, and value for the health-care system. For over 30 years, regulations have limited the population served by the program.

Given our growing, aging population, would you please describe in detail how you plan to enhance the successful work of PACE and other models to ensure that frail elderly patients who want community-based care, as opposed to institutional care, can get it.

Answer. I look forward to working with the staff at CMS to get their input on how we can better serve our aging population as we implement PACE or other related policies enacted by Congress.

PAYMENT REFORMS

Question. Patients, providers, as well as public and private payers benefit when valid, reliable, and risk-adjusted scientific measures are used to assess functional outcomes, support evidence-based clinical decision-making, and measure quality. Using these tools also assures the best value for dollars spent. Under your leadership will CMS continue to pursue further expansion of the Merit Based Incentive Payment System (MIPS) to other eligible providers such as physical and occupational therapists?

Answer. I look forward to working with providers to implement MACRA as designed by Congress. I will work with the staff at CMS and providers to evaluate whether the MIPS program is achieving Congress's goals while ensuring that the impact on patients and the providers who care for them are at the center of any future reform efforts. It is especially important that we carefully consider feedback from providers on the frontlines of health care, especially those smaller providers or those providers in rural settings.

PRESCRIPTION DRUGS

Question. The Patient Protection and Affordable Care Act's numerous patient protections have greatly helped beneficiaries, especially those living with chronic and serious health conditions such as HIV/AIDS and hepatitis, access the care they need to stay healthy. Of particular importance to the patients I represent, the regulations implementing the law's Essential Health Benefits (EHBs) and Non-discrimination provisions require health plans to use Pharmacy and Therapeutics committees to develop and regularly update their formularies; cover a minimum number of drugs in each therapeutic class; provide cost-sharing, tiering, and utilization management information to enrollees and potential enrollees; have an exceptions and appeals process for accessing non-formulary drugs; and design and implement their benefits in a way that does not discriminate against or discourage enrollment by individuals living with particular health conditions.

As CMS administrator, would you ensure that the critical patient protections afforded by the ACA remain and are enforced at the Federal level?

Answer. If confirmed, it will be my duty to implement the laws passed by Congress and I look forward to evaluating the impact on patients and working with you to ensure patients are able to access high quality care.

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

THERAPY CAPS

Question. As you may know, limits on outpatient rehabilitation therapy services under Medicare were first imposed in 1997 as part of the Balanced Budget Act without regard to its impact to access on needed therapy services. Congress has acted several times to prevent the caps from going into effect by passing moratoria. Later

in 2006, Congress created an "exceptions process" for beneficiaries whose conditions required more care than the annual limits would allow and at the end of 2015 year, Congress again extended the exceptions process by 1 year. The current therapy cap for occupational therapy (OT) is $1,920 and the combined cap for physical therapy (PT) and speech-language pathology services (SLP) is $1,920.

What is the impact on seniors that hit the cap?

Answer. If confirmed, I look forward to looking into the impacts of these statutory caps on seniors. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed, I will look at our Medicare system holistically to make sure that we are delivering access to quality, affordable health care to our citizens.

Question. Do you support repealing the Medicare cap on therapy services?

Answer. If confirmed, I look forward to working with Congress on this issue and providing technical assistance that you or others interested in Medicare therapy caps may need.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

MEDICAID EXPANSION AND ADDICTION TREATMENT IN OHIO

Question. Your consulting firm, SVC, has played a role in developing Medicaid waiver proposals for a number of States including Ohio's proposal, the Healthy Ohio Program, last year.

As you know, CMS denied Ohio's waiver application, citing concern that monthly premiums and late payment penalties would "not support the objectives of the Medicaid program, because (they) could lead to a substantial population without access to affordable coverage."

At a time when Ohio is at the height of an opioid epidemic, it is important to maintain coverage and access to care for the more than 500,000 Ohioans receiving mental health and addiction treatment through Medicaid—including more than 150,000 who now have coverage through Medicaid expansion.

When Ohio submitted its waiver plan, data included in its application estimated that the policies proposed would lead to more than 125,000 Ohioans losing coverage.

Given the opioid epidemic across the Nation and the critical role Medicaid plays in helping individuals access needed care, including medication assisted treatment, it is critical that the Administrator of CMS evaluate State waiver requests to ensure that no individual struggling with addiction or a mental health condition loses coverage or access to affordable coverage.

Would you approve a State's Medicaid waiver request if the resulting waiver would result in a loss of coverage or access to coverage for individuals struggling with addiction or other mental health conditions—"yes" or "no"?

Answer. To the extent I am not required to recuse from a particular matter under the terms of my Ethics agreement, I will carefully review any waivers on a case-by-case basis. I will consider all factors as required by law including evaluating the State's waiver request to ensure that all individuals struggling with addiction or a mental health condition continue to have access to treatment.

Question. If confirmed, will you continue to support innovative models to improve treatment outcomes for individuals seeking addiction treatment, such as through the 1115 waivers, home health models, and the Innovation Accelerator Program?

Answer. To the extent I am not required to recuse from a particular matter under the terms of my Ethics agreement, I will support effective, best practice, innovative treatment models. Opioid addiction has had a severe and devastating impact on communities and families across the country. If confirmed, I am committed to working with States to protect access to treatments and help low-income adults with mental health and substance use disorders through existing and evidence-based innovative solutions for these problems. To the extent I am not required to recuse from a particular matter under the terms of my Ethics agreement, I will work with States to ensure that access to treatment is not diminished.

INFANT MORTALITY AND TOBACCO

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

We don't know exactly why Ohio does so poorly when it comes to infant mortality, but one thing that we do know is that health complications caused by preterm births are the leading causes of infant mortality.

We also know that a major factor in premature births is tobacco use, and Ohio's smoking rate among pregnant women is nearly twice the national rate.

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

Medicaid covers nearly 50% of births in this country.

Do you support the current requirement that State Medicaid programs provide pregnant women with effective tobacco cessation services without cost sharing—"yes" or "no"?

Will you work within the administration and with Congress to maintain this requirement so that all pregnant women—regardless of their income—have access to tobacco cessation services—"yes" or "no"?

Answer. The science is clear that tobacco use during pregnancy is risky for both moms and babies. States should have maximum flexibility to prioritize critical health risks such as smoking during pregnancy. The decision to maintain this requirement, however, is a legislative matter that rests with Congress.

FAIR PAY/HOMECARE WORKERS

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

If confirmed as CMS Administrator, will you commit to working with your colleagues at the Department of Labor to support and advance policies to ensure women across the health-care workforce and reimbursed by CMS are paid fairly—and treated equally as compared to their male counterparts—regardless of their job—"yes" or "no"?

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

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

Past leadership at CMS committed *in writing* to exploring Federal actions under its current authority that could work with States to strengthen and support home care workers. It is important to me that this issue remain a priority for the current administration.

If confirmed, will you commit to continuing this work to ensure fair pay and advancement opportunities for the home care workforce—"yes" or "no"?

Answer. I firmly believe that women should be compensated based on their ability and their contribution to the workforce, not based on their sex. If confirmed, I look forward to working with HHS and CMS staff as well as the Department of Labor to evaluate these important issues.

EPSDT

Question. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit became an additional benefit for children in the Medicaid program in 1967. The EPSDT benefit establishes guidelines which ensure unlimited access to medically necessary, age-appropriate screenings and preventive care for children, including well-child exams.

Providing preventive care services through EPSDT is essential for ensuring that every child has the opportunity to become a healthy adult. Are you committed to maintaining existing standards for child health care in the Medicaid program?

Are you committed to ensuring that States enforce EPSDT so that children are able to access the services they need?

One major threat to the EPSDT benefit and the health of children in this country is the possibility of restructuring Medicaid into a block grant or per capita cap, proposals which you have supported.

If confirmed, can you guarantee that you will uphold the current standards of coverage, affordability, and especially of pediatric-appropriate benefits for children through the Medicaid program?

Answer. Our goal is to ensure every single American has access to the coverage they want for themselves or their children and dependents, and children are, and will continue to be, a high-priority population within the Medicaid program. States are well-positioned to determine the most appropriate ways to ensure access to the highest quality care for children, which may include diagnosis and screening procedures and the illnesses and conditions they uncover. As this is a matter for Congress, I look forward to working with Congress to improve our Medicaid system.

EPSDT LEAD TESTING STANDARDS

Question. One important provision in the EPSDT benefit is screening and testing for lead poisoning. More than a half a million children between the ages of 1 and 5 are estimated to have blood lead levels above the level at which the CDC recommends public health actions be taken.

Despite these numbers, millions of at-risk children are never screened and tested for high lead levels despite early childhood lead screening and testing requirements. In fact, a Reuter's investigation last year found that less than half of the 1- and 2-year-olds enrolled in Medicaid—just 41 percent—are tested for lead exposure as required.

Last year, I was the lead author of a letter sent to CMS with more than 40 of my Senate colleagues to urge the agency to improve lead screening and testing across at-risk communities and do everything it can to help health-care providers quickly identify and track children who have been exposed to lead.

Administrator Slavitt responded positively to that letter, and CMS put out an informational bulletin at the end of the year to help States improve their screening rates.

If confirmed as Administrator of CMS, what specific next steps will you take to improve blood lead testing covered by the Medicaid program and ensure adherence to the EPSDT benefit for both screenings and follow-up treatment services?

Answer. The Flint water crisis has highlighted the inherent dangers of lead poisoning and the importance of avoiding such exposure particularly for the young, elderly, and infirm. If confirmed as CMS Administrator, I look forward to working with my CMS colleagues to learn more about potential deficiencies in the EPSDT's lead testing standards and potential solutions for such problems.

PREVENTIVE SERVICES WITH MEDICARE

Question. As you know, the ACA eliminated cost-sharing for preventive services covered under Medicare. Since the change took effect in 2011, Ohio seniors have benefited from access to life-saving screenings and wellness visits at no cost to them. In fact, more than 885,000 Ohio seniors had at least one preventive Medicare service in 2015.

Are you in favor of repealing the ACA provisions that expanded cost-free preventive services in Medicare? If so, do you acknowledge that this will increase Medicare beneficiaries' out of pocket expenses?

Which preventive services that are currently provided to Medicare beneficiaries without any copay do you believe should continue to be offered at no out-of-pocket cost?

Considering President Trump's executive order to "ease the burden" of the ACA, how will you ensure that Medicare beneficiaries do not lose coverage of services they have relied upon—and in some cases, services that have saved lives—for the last 6 years?

Answer. Should I be confirmed as Administrator of CMS, my duty will be to execute the law as passed by Congress and signed by the President. Ultimately, the question of ACA repeal is a legislative matter for Congress to decide.

MEDICARE ADVANTAGE UNDER THE ACA

Question. Your history in Indiana shows an interest in expanding the use of private insurance in the Medicaid space. This option is increasingly utilized in Medicare through Medicare Advantage plans. Previously, Medicare Advantage plans paid over 110% of the cost of a service compared to traditional Medicare spending, but this provision was removed through the ACA. If the ACA is repealed, it is assumed that these spending differences would be re-instated.

Do you believe that Medicare Advantage plans should be paid more than what traditional Medicare spends on a given patient? Why or why not?

Will you support or allow unequal reimbursement as compared to FFS Medicare through overpayments by CMS to Medicare Advantage plans?

What will you do to ensure taxpayer dollars are utilized appropriately under the Medicare program when it comes to parity between FFS Medicare and MA?

Answer. Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. If confirmed as CMS Administrator, I would seek to ensure Medicare Advantage remains a stable option for beneficiaries and that Medicare Advantage issuers are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want. It is my intention to fairly and accurately monitor the quality and effectiveness of our entire care system, including Medicare Advantage and original FFS Medicare.

MEDICARE ADVANTAGE BILL OF RIGHTS

Question. As you know, the Medicare Advantage population is approaching one-third of all Medicare enrollees, and continues to grow. Last month, CMS published a review of more than 50 Medicare Advantage organizations that showed widespread inaccuracies in their provider directories published online.

Inaccuracies ranged from listing the wrong location for a provider to including providers who were not accepting new patients even though the website said they were. This is a clear problem for an increasing number of consumers that should be addressed.

If confirmed, what tools will you use to hold Medicare Advantage plans responsible for complying with program rules?

Since oversight is one of the primary responsibilities of the Administrator for CMS, what specific proposals do you have to strengthen consumer protections in Medicare Advantage?

In addition to getting away with publishing inaccurate provider directories, Medicare Advantage plans can also drop providers mid-year without warning their beneficiaries.

That's why I have previously introduced legislation, the Medicare Advantage Bill of Rights, to prohibit Medicare Advantage from dropping providers without cause mid-year. It would also require Medicare Advantage plans to finalize their provider networks 60 days before open enrollment so that patients have the information they need before signing up for a plan. This fix does not require legislation. CMS can actually make this change on its own.

Will you commit to strengthening beneficiary protections in Medicare Advantage by ensuring Medicare Advantage insurers are prohibited from dropping providers mid-plan year without cause?

Answer. Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. CMS should always make sure that seniors are in the driver's seat of their health care and have necessary, timely, and accurate information to make health-care decisions. Oversight is an important responsibility of CMS. If confirmed as CMS Administrator, I would seek to ensure Medicare Advantage plans comply with regulations and laws to ensure it remains a stable option for beneficiaries and that Medicare Advantage issuers are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want.

I would also look forward to working with my CMS colleagues to learn more about the options for strengthening beneficiary protections in Medicare Advantage, including improving the accuracy of provider directories. I welcome recommendations, particularly those that are evidence-based, that would achieve these results.

QUESTION SUBMITTED BY HON. SHERROD BROWN AND HON. ROB PORTMAN

NURSING EDUCATION

Question. The demand for nurses is on the rise, and the Bureau of Labor Statistics estimates that the United States will face a 1.2 million nurse shortage by 2020. Ohio is home to 12 hospital-based nursing programs that receive Medicare pass-through funding for nursing education, which will help supply qualified professionals to meet the demands for the growing nursing workforce. Unfortunately, these hospital-based institutions are in jeopardy as they face competing qualifications between CMS's regulations and evolving accreditation requirements.

To combat this threat to the funding of nursing education, we have introduced legislation in past Congresses—the MEND Act—which would simply ensure continued CMS support of nursing education through pass-through funding at hospital-based nursing schools.

If confirmed, will you commit to working with us on ways to ensure these institutions do not lose access to their pass-through funding, both through administrative action and through working with legislators to craft and quickly implement a solution that will allow for the continued education of nurses at hospital-based nursing programs?

Answer. I look forward to working with you on this issue to share feedback and technical assistance on policies relating to nursing education funding, which has a broad geographic scope and impact. If the laws on the issue are enacted, and if confirmed, I will work to implement the laws on the timeline Congress imposes.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN, HON. ROBERT MENENDEZ, HON. MICHAEL F. BENNET, HON. ROBERT P. CASEY, JR., AND HON. RON WYDEN

LABORATORY PAYMENTS UNDER PAMA

Question. Congress passed the Protecting Access to Medicare Act (PAMA) in 2014. This bipartisan law included policies to update and change the way Medicare reimburses clinical laboratories under the Clinical Laboratory Fee Schedule (CLFS), moving the reimbursements towards a market-based payment methodology. Under the law, all "applicable" laboratories are required to report to CMS the payment rates and test volumes for their private payers.

CMS finalized PAMA regulations in June 2016, and released further guidance in September 2016, which impose an unrealistic reporting timeline for laboratories. Additionally, we have heard from our regional and community-based laboratories about significant concerns they have about their ability to report accurate data and how the current rules' exclusion of market data from hospital outreach labs and definition of "applicable laboratory" will impact the accuracy of CMS's data.

If confirmed, will you commit to looking at the current PAMA regulations and reporting requirements to ensure that independent, physician and hospital laboratories are appropriately and accurately accounted for in the market price data? Further, will you commit to evaluating the need to extend the March 31, 2017, reporting deadline to ensure that laboratories—especially smaller, community laboratories—are able to successfully collect and report the data required under the regulations?

Answer. Accuracy in reporting and data collection is essential for a market to thrive. In this case, we should certainly strive for accuracy in this market data collection process. I look forward to following up with CMS staff and regional and community-based laboratories to discuss workable solutions.

CDS UNDER PAMA

Question. In addition to the issue in my previous question related to PAMA, I have heard from Ohio constituents who have concerns over the clinical decision support (CDS) mechanisms included in PAMA as it relates to advanced diagnostic imaging tests for Medicare Part B, including the use of appropriate use criteria (AUC) in the decision-making process. I have heard concerns that CMS's new regulation threatens PAMA by putting severe limitations on the diagnostic imaging provision by limiting CDS to just 8 priority clinical areas (PCAs).

Given your knowledge and previous work with CDS, if confirmed, will you work to implement CDS as fully intended by Congress? What specific actions will you take to ensure uptake of CDS in all PCAs?

Answer. If confirmed as CMS Administrator, I would have a duty to implement laws as passed by Congress.

DIR FEES

Question. In your hearing, you mentioned that Pharmacy Benefit Managers (PBMs) are negotiating prices for Part D, and you're glad that they do. I think that more can be done to negotiate lower drug prices for our seniors, and there is a lack of transparency with the status quo. This lack of transparency and limited capacity to negotiate results in higher costs for consumers and can result in significant challenges for small community pharmacies and long-term care pharmacies. These pharmacies are facing increased uncertainty because of Direct and Indirect Remuneration (DIR) fees imposed by PBMs.

CMS has recognized some of these issues, and in January released a fact sheet showing that the use of DIR fees by Part D sponsors has been "growing significantly in recent years" and has led to an increase in beneficiary cost-sharing, an increase in subsidy payments made by Medicare, and an overall decrease in plan liability for total drug costs.

What role do you believe retroactive DIR fees have on exacerbating closures and consolidation across the delivery system?

If confirmed, what specific steps would you take to improve transparency between plans and pharmacies in the use of DIR fees in the Medicare program?

Would you make it a priority to re-visit the September 2014 proposed guidance (Proposed Guidance on Direct and Indirect Remuneration and Pharmacy Price Concessions) to standardize the timing of how these fees are reported, that has not yet been finalized?

Answer. If confirmed, I will welcome the opportunity to work with Congress and all stakeholders, including small community pharmacies and long-term care pharmacies, to preserve seniors' access to drugs. Additionally, I look forward to working with you to consider how to resolve this pending guidance issue. I would be happy to discuss the September 2014 Proposed Guidance on Direct and Indirect Remuneration and Pharmacy Price Concessions and other related issues with you.

PROVIDER STATUS

Question. It is estimated that by 2020, the United States will face a shortage of more than 91,000 doctors, which will be particularly painful in rural underserved areas like we have in Ohio and you in Indiana. I am an original cosponsor on a recently introduced bipartisan, bicameral bill, the Pharmacy and Medically Underserved Areas Enhancement Act, which would recognize pharmacists as providers in the Medicare program. This would allow pharmacists to serve beneficiaries in underserved areas by utilizing their advanced education, training, and consultation abilities to provide many Medicare services in addition to their essential role in administering and educating patients about their prescription medications.

As CMS Administrator, what will you do to support the utilization of pharmacists to their full scope as a way to improve access to care and keep costs low for Medicare beneficiaries in underserved areas?

Answer. If confirmed, I would be open to various solutions to address the impact of the ongoing physician shortage in underserved areas. Where permitted by law, I would consider the possibility that paying pharmacists in rural areas to engage in certain medical services could work well in those States where pharmacists have such licensure and a setting appropriate for the services, where primary care doc-

tors continue to be involved in care, and where there is a patient and consumer demand for such services.

OBSERVATION STATUS

Question. During your hearing, I tried to engage you on the issue of observation status for Medicare beneficiaries. As I mentioned, the NOTICE Act will initiate MOON notice requirements in just a couple of weeks, but this legislation does not address the underlying problem imposed by the 3-day stay rule.

To follow up from the hearing, I hope you have had time to review the obstacles facing our seniors' access to affordable care in SNFs under current regulations. My Improving Access to Medicare Coverage Act, which I plan to reintroduce next month, would enable time that beneficiaries spend in the hospital under observation to count toward the 3-day requirement for Medicare coverage. I appreciate that you are willing to work with me on this huge issue for Ohioans, and hope that you will support my legislative efforts with this reintroduction.

Have you had time to review this provision of law and provide some suggestions on ways to improve this issue for Medicare beneficiaries?

Should you be confirmed, will you commit to swiftly issuing an opinion on CMS's authority in this regard?

If confirmed, will you work to administratively correct this billing technicality that adversely impacts Medicare beneficiaries and work with Congress to correct this issue via legislation, if necessary?

Answer. If confirmed, I will monitor the implementation of the NOTICE Act and the utilization of the Medicare Outpatient Observation Notice (MOON). I will also work to identify if more may need to be done with regard to this observation status issue to improve seniors' access to care in SNFs. And if the best path forward involves legislation, I would be pleased to work with you and provide technical assistance on that as well.

MEDICAID AND CHIP QUALITY OF CARE

Question. Over a decade ago, Congress enacted legislation to begin shifting the metrics in our health system away from paying for volume to paying for quality and safety. In recent years, this shift towards quality has shown improvement in important areas like rates of hospital acquired infections and hospital readmission.

However, there is still much work to be done, especially for our most vulnerable populations. That's why I have introduced the Medicaid and CHIP Quality Improvement Act (MCQA) in past Congresses, to encourage data collection and define quality assessments for the more than 80 million Americans who currently receive care through these programs with no structured quality measures.

I know that you understand the value of quality measures and holding States accountable for improving quality for Medicaid beneficiaries. I also know that you understand how collecting data for quality assessments of the Medicaid and CHIP populations is tremendously challenging given the wide variation across States.

Do you believe that Congress and the administration should know the defined quality of care that State Medicaid and CHIP programs are delivering for that investment?

Answer. Yes, and we should hold States accountable for achieving outcomes. To this end, we must ensure that State Medicaid programs are not beset by unnecessary administrative burdens that could impede progress on achieving this goal.

Question. Would you be willing to work with Congress to try to implement and improve quality measurements for these vulnerable Americans across different structures and delivery mechanisms of the program?

Answer. Yes. If confirmed as CMS Administrator, ensuring high-quality care in Medicaid and CHIP will be one of my top priorities.

MEDICARE QUALITY OF CARE

Question. If confirmed, as Administrator of CMS, you would also have authority over the Medicare program and its budget of close to $600 billion dollars. This includes the ability to enact regulations and establish guidelines for reporting requirements.

How would you specifically encourage collaboration between the Federal Government and individual States to identify program standards and incentives in Medicare programs?

Some plans, including my MCQA legislation, champion incentivizing State performance in quality metrics. How would you oversee any such incentives programs?

Answer. The States are well positioned to provide for the unique health-care needs of their residents. If confirmed, I would work to see that CMS is a helpful resource to the States. CMS can offer clarity regarding State flexibility, technical assistance, and provide support as needed to promote effective policies and practices.

ACCOUNTABILITY

Question. In your work with SVP you have worked with States to craft Medicaid programs that require beneficiaries to pay premiums and potentially lock individuals out of coverage if they do not pay. Your website states that you have developed reform programs and waivers for other States, including Kentucky.

Last year, Kentucky Governor Matt Bevin submitted a proposal modeled on Indiana's Medicaid expansion waiver that would go even further than Indiana's proposal by instituting a work requirement as a condition of eligibility for some beneficiaries. CMS has not approved this waiver, and has stated that work requirements are not consistent with the original intent of the Medicaid program or consistent with Federal Medicaid law.

Studies have shown that the main effect of work requirements likely would be the loss of health coverage for substantial numbers of people who are unable to work or face major barriers that prevent them from holding part-time or full-time employment. Additionally, State Medicaid agencies would be stretched just covering the basic costs of administering and enforcing these requirements.

As CMS Administrator do you plan to uphold the agencies previous decisions of not approving work requirements under Federal Medicaid law?

Do you believe a child should be held responsible—and potentially lose health insurance coverage—if their parent does not pay a Medicaid premium or participate in a work requirement as required under some of the programs you have helped draft?

Answer. Studies have confirmed the value of work to individual health and sense of well-being, and Medicaid has an historic role as part of a broader anti-poverty effort. If confirmed, I look forward to working with States to consider innovative strategies that improve outcomes. Every potential policy should consider the impact on the different Medicaid populations, while ensuring appropriate protections are in place for vulnerable populations like children.

CMMI

Question. As acknowledged during both your and Secretary Price's testimonies, CMMI is an important tool that exists within CMS for the testing and development of new, patient-centric, value-based payment models. These models will be critical to informing the future of care delivery.

Are you committed to preserving CMMI?

Answer. If confirmed, I plan to work with the Secretary to ensure that CMMI, or the "Innovation Center,"—after consultation with Congress, the States, healthcare stakeholders, and Innovation Center staff—tests appropriate innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries. As such, I look forward to reviewing current CMMI projects, consistent with congressional actions.

Question. How do you plan to involve both stakeholders and Congress in the development and implementation of models?

Answer. Stakeholder engagement is crucial in the development of innovative models. For instance, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) establishes the Physician-Focused Payment Model Technical Advisory Committee, to review proposals for physician-focused payment models that can ultimately be adopted through the Innovation Center. Communication and collaboration with Congress and stakeholders throughout the process is a major priority as CMS moves forward with implementing the law and fostering innovation.

DUAL ELIGIBILITY/CMMI/MEDICARE STANDARDS

Question. ASPE recently released a report that concludes dual status is one of the most powerful predictors of outcomes and that, with time, outcomes can be improved.

What additional actions can and should CMS take to do more to help support programs and the integration of Medicare and Medicaid for duals?

Answer. Sound integration between Medicare and Medicaid requires that regulations and administrative processes properly align. If confirmed, I will work to ensure that CMS continues to make progress in this area.

MEDICARE/HEALTH SYSTEM TRANSFORMATION

Question. As Congress and the administration work to incentivize new models of care, it is important that we collect information from States and providers to help inform policy decisions and ensure quality and access.

If confirmed, how will you ensure CMS is monitoring beneficiary access to care across new delivery system models? What factors will you use to measure access to care?

Answer. Our goal is to ensure access to affordable, quality health care for all Americans, including individuals in rural or underserved areas. Accordingly, the best metric in the end is one that measures the extent of access to actual care, not just coverage, and the quality of that care as determined by patients working individually with their doctors. I look forward to partnering with States to best determine the real-life impact of health-care policy at the local level. We must hold States and providers accountable for enabling access to quality care.

Question. If beneficiary access is hindered, how do you envision addressing these issues and ensuring access to care?

Answer. I intend to work expediently with the Congress, the Secretary and CMS colleagues to strive for improved access to care, especially when access to care may be threatened. Our decisions must be data-driven and made with a focus on addressing the unique needs of the patients in question.

Question. What advocacy organizations—and specifically consumer groups—will you engage in evaluating these alternative payment models throughout the stages of development and implementation?

Answer. I appreciate feedback across the health-care industry to ensure workable payment models are being pursued. Organizations that represent consumer groups are especially important to engage with to understand the impact of the models on beneficiary care, both on the front end and throughout the development and implementation of the models.

Question. How will you ensure CMS hears directly from impacted beneficiaries and resolves issues immediately so that access is not affected?

Answer. The fundamental metric for knowing that our system is on the right track is the centrality of the patient in the system and their ability to make choices about their care in consultation with their doctor. Restrictions on access to care threaten this principle and ought to be swiftly examined. I look forward to working with CMS to ensure we have an open line of communication with beneficiaries.

OUT-OF-POCKET PROTECTIONS FOR MEDICARE POPULATION

Question. Seniors are often on fixed incomes, and their yearly income certainly does not grow at the rate of medical inflation, however, out-of-pocket costs as a share of income continues to rise for Medicare beneficiaries each year. While the ACA helped protect Americans from caps on annual and lifetime out-of-pocket caps, this consumer protection does not exist for Medicare beneficiaries.

What will you do, if confirmed, to help keep costs low for beneficiaries and protect seniors on fixed incomes from growing out-of-pocket costs?

Answer. I would convey to Medicare beneficiaries that I look forward to working with Congress to make certain that we preserve and strengthen Medicare for seniors.

MEDICARE 2-YEAR WAITING PERIOD

Question. As I'm sure you know, individuals who are under the age of 65 with a disability are generally required to wait for 2 years after receiving SSDI before they are eligible for Medicare coverage. Thanks to the ACA, individuals who are waiting for Medicare based on SSDI eligibility can sign up for insurance through the individual exchanges while they are waiting for Medicare eligibility to kick-in.

If the ACA is repealed, what will you do as Administrator of CMS to ensure coverage options for these vulnerable individuals?

Answer. Our goal is to ensure access to affordable, quality health care for all citizens, including individuals with disabilities. As such, I look forward to implementing the laws passed by Congress to enable affordable, quality care for individuals with disabilities.

MEDICARE PRESCRIPTION DRUG PRICES

Question. During your hearing, Senator Wyden asked you about soaring drug prices affecting seniors through Medicare Part D. I think you agree with many of us, and many Americans as you noted, that the prices of these prescription drugs are out of control and it should be a goal to make these drugs accessible and affordable to all Medicare beneficiaries.

It is imperative that the American public and legislators know, if confirmed as CMS Administrator, how (specifically) will you address this drug pricing issue?

Do you intend to use CMMI authority to test new methods to bring down Medicare drug spending? If so, how might you direct this authority?

Answer. The issue of drug costs is one of great concern to all Americans. You have my commitment that I will work with you and others to make certain that Americans have access to the medications that they need. I share your concern regarding the importance of individuals and families being able to afford the prescription drugs they need. If confirmed, I look forward to working with HHS, CMS, and FDA to consider potential options to address the issue of access to, and the affordability of, prescription drugs.

MEDICAID CHURN

Question. Medicaid churn—or the continual disenrollment and re-enrollment, which can be caused by changes in income or changing life circumstances—can interrupt continuity of care and access to important services in the Medicaid population. This can be particularly disruptive for Medicaid beneficiaries using care coordination and care management services, which are interrupted every time a beneficiary is disenrolled.

In your work with Medicaid, how have you helped mitigate the negative impacts of churning?

Answer. One way to mitigate the impact of Medicaid churn is to institute enrollment and payment policies and procedures that are as consistent as possible with the commercial health insurance market. Coordination between State workforce development programs that help Medicaid members become more upwardly mobile can also help eliminate churn.

Question. How will you ensure that eligible individuals will remain covered in Medicaid, even when there are changes in their life circumstances at no fault of their own?

Answer. It is important that Medicaid's enrollment and payment policies strike the right balance between fairness and responsibility and contain the appropriate safeguards that consider changing circumstances for families.

PHYSICIAN REIMBURSEMENT

Question. On average, Medicaid pays providers about 70 percent of what a Medicare provider receives for the same service. The only difference is the age of the patient being served.

There are 45 million children and 30 million adults enrolled in Medicaid. As you noted in your hearing, you want all patients to be able to access any doctor they choose, but typically low Medicaid payments—that are set by States—can impede the ability of providers to accept more patients—both pediatric and adult—covered through this program.

Along with Senator Murray, I have worked to introduce the Ensuring Access to Primary Care for Women and Children Act in past Congresses, legislation that would solidify parity between Medicare and Medicaid reimbursements for primary care. If confirmed, you would oversee the budgets of both Medicare and Medicaid, and would be looked to for guidance on the issue of appropriate Medicaid reimbursement rates.

Do you believe that a child's care should be valued at only 70% of that of an adult?

Answer. No. Medicaid has a complex financing and payment system that includes base rates set by States, supplemental payments to providers, and other Federal and State funding sources for care to the Medicaid or uninsured populations.

Question. If a State's Medicaid budget is cut by a per-capita-cap or block grant proposal, how will you prevent States from cutting reimbursement rates for providers to even worse than they are now?

Answer. I look forward to working with Congress on the specifics of any new Medicaid financing and payment proposals in order to hold States accountable to ensure patient access to high quality health care.

PREEXISTING CONDITIONS

Question. As Senator Wyden said during your confirmation hearing, Americans cannot afford to go back to the days of when health care was only for the healthy and wealthy. I strongly believe that if pieces of the ACA are repealed, any replacement must ensure that every American—regardless of whether they are a woman, have cancer, ESRD, or any other condition or preexisting condition—has access to affordable, comprehensive coverage equal to or better than coverage options currently available through the ACA, regardless of their income.

I'm concerned that a one-sized-fits-all approach, like high risk pools, leaves those who truly need high quality and affordable health care out of luck.

How will you ensure that those with the greatest needs will have continued access to high-quality health care?

Answer. I believe it is important that we as a nation make sure that every American has access to the kind of health care and health coverage that best meets their needs. Additionally, it is imperative that all Americans have access to affordable coverage and that no one is priced out of the market due to their diagnosis. Nobody ought to lose insurance because they get a bad diagnosis. If confirmed as CMS Administrator, I intend to implement the laws passed by Congress to ensure access for all, including those with pre-existing conditions, is affordable.

MEDICAID GUARDRAILS

Question. Through your work at SVC, you have helped several States attempt to change their Medicaid plans.

In your experiences, what evidence have you seen that Medicaid guardrails help beneficiaries gain employment, transition off of Medicaid onto different health insurance coverage, and achieve other Stated goals of the individual programs?

Is there any evidence that these requirements increase burdens by adding costs to the programs or by increasing administrative challenges and inefficiencies?

Answer. I have been fortunate to be involved in many proposals and initiatives to help Medicaid beneficiaries along the lines described. In my experience, meeting Federal requirements like guardrails can be a limitation on State innovations and do not necessarily improve health outcomes. If confirmed as Administrator, I would endeavor to ensure States are given the flexibility to pursue innovative approaches that fit their needs while ensuring access to care.

BIOSIMILARS

Question. During your hearing, Senator Roberts asked you about the need for CMS and FDA to work together to promote the uptake of biosimilars and enhance innovation across agencies to reduce costs of prescription drugs. I agree collaboration between agencies on this issue is important. I have also introduced legislation in the past that would help achieve this by shortening the patent exclusivity period for expensive, brand-name biologic drugs and allow biosimilars to enter the market sooner. Biosimilars, which are equivalent in safety and efficacy to their reference biologics, have the capacity to reduce prescription drug costs, yet physicians must

be willing to prescribe them and patients need the information necessary for them to be confident in taking them.

As CMS Administrator, how would you work with FDA to develop this burgeoning market and promote biosimilar uptake?

As you mentioned multiple times in your hearing, you want to make sure all patients have access to the drugs that they want to take. Because the costs of drugs is an important factor in that decision, increasing the availability of biosimilars is an important step in that process and will ensure beneficiaries have access to choices when it comes to their prescription drugs.

Educating patients and providers is an important component to ensure the widespread use of biosimilars. It is vital that providers are well informed about how a biosimilar can be prescribed, and how and when an interchangeable product can be substituted for another biological product. Simultaneously, it is imperative that patients, too, have confidence in the safety and efficacy of a given FDA-approved biosimilar.

Please describe specific examples of patient and provider education efforts that you will encourage the FDA to engage in regarding biosimilars, if you are confirmed.

Answer. If confirmed, under my leadership, CMS will work with the FDA to help ensure that Medicare and Medicaid beneficiaries have guidance on biosimilars. I understand that this will be increasingly important as more of these products are expected to become available to U.S. patients in the coming years.

QUESTION SUBMITTED BY HON. SHERROD BROWN AND HON. BENJAMIN L. CARDIN

THERAPY CAPS

Question. As you may know, limits on outpatient rehabilitation therapy services under Medicare were first imposed in 1997 as part of the Balanced Budget Act without regard to its impact to access on needed therapy services. Congress has acted several times to prevent the caps from going into effect by passing moratoria. Later in 2006, Congress created an "exceptions process" for beneficiaries whose conditions required more care than the annual limits would allow and at the end of 2015 year, Congress again extended the exceptions process by 1 year. The current therapy cap for occupational therapy (OT) is $1,920 and the combined cap for physical therapy (PT) and speech-language pathology services (SLP) is $1,920.

What is the impact on seniors that hit the cap?

Do you support repealing the Medicare cap on therapy services?

Answer. If confirmed, I look forward to reviewing the impact of the statutory caps on seniors. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed, I will look at our Medicare system holistically to make sure that we are delivering quality, affordable health care to our citizens.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. This week, I worked with Senator Grassley to reintroduce the Advancing Care for Exceptional (ACE) Kids Act. The bill would help hospitals and other providers coordinate and standardize care across State lines for children with complex medical conditions. As you may know, Medicaid covers about two-thirds of the 3 million children with complex medical conditions. This represents nearly 40% of Medicaid costs for children. The bill is expected to reduce the burden on families who are often managing multiple specialists, improve outcomes, and lower costs.

Does the administration support this concept? What are some other ways the administration may seek to help families who must care for children with complex medical conditions.

Answer. If confirmed, I would support efforts to help coordinate care. I would start by working with my colleagues across the Department to identify all the ways in which HHS aims to help these children in need. And I would hope to encourage our use of existing authorities and funding to better align resources to meet this

challenge, especially at CMS. I would also work with you and other members of Congress on their ideas on this important topic.

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

Would the administration consider piloting such a program through the CMS Innovation Center?

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

Question. Colorado has a strong commitment to community living and home and community based services. This includes a Community Mental Health Supports waiver, an Elderly, Blind, and Disabled waiver, and a Children with Autism waiver. We have several others that support the most vulnerable in the community.

How can we support older Americans and individuals with disabilities who choose to live in the community?

What additional flexibility do States need to innovate through waivers?

Answer. The goal of CMS is to ensure access to affordable, quality health care for all citizens. This, of course, includes people with disabilities who depend on Medicaid. If confirmed, I hope to implement the law so as to allow States the flexibility to approach this population in a way that makes sense for their program and its beneficiaries, so long as it is done in accordance with Federal law.

Question. Colorado has participated in many multi-payer initiatives like the Comprehensive Primary Care Initiative and the State Innovation Model and has worked closely with the Center for Medicare and Medicaid Innovation. Our Medicaid program is also participating in the demonstration project for individuals dually enrolled in Medicare and Medicaid. The State also has a highly successful Accountable Care Collaborative delivery system model.

Moving forward, how do you foresee CMS preserving these types of innovations?

What steps will you take to ensure that CMMI models increase quality and access to care for patients?

How will you ensure that innovative demonstrations are developed with input from clinical experts and interested stakeholders?

Answer. While I cannot comment on specific demonstrations at this time, if confirmed, I plan to work with the Secretary to ensure that the Innovation Center—after consultation with Congress, the States, healthcare stakeholders, and Innovation Center staff—tests appropriate innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries. As such, I look forward to reviewing all current CMMI projects, consistent with congressional actions.

Question. Over 700,000 Coloradans live in a rural community. The Medicaid Expansion provided some financial stability to rural hospitals that were on the brink of closure before the Affordable Care Act. In fact, hospitals in Colorado saw a 30% drop in uncompensated care. I have heard from rural hospitals in our State that several will face significant financial challenges if the law is repealed. This is concerning, considering that there are counties in Colorado without access to a clinic or a hospital.

Would you support an Affordable Care Act replacement bill that reduced access to health care in rural communities?

How would a replacement ensure that these communities continue to have access to quality health care?

Answer. Oftentimes rural health-care providers and patients are overlooked in the broader discussion of national health-care issues. Significant health disparities exist for rural populations for a variety of reasons, including challenges with access to

affordable coverage and health-care services. Moreover, small rural providers face a unique set of challenges depending on where they are, who they serve and what Federal and State requirements they are subject to. If confirmed, I will work tirelessly to address the health-care needs of all Americans, rural or urban. I look forward to working with Congress to implement the laws they pass to ensure every single American has access to the coverage they want for themselves and that individuals who lost coverage under the Affordable Care Act get or maintain coverage. This of course includes individuals who access care at rural hospitals or clinics.

Question. A Colorado-based orthopedic practice is participating in one of CMMI's voluntary demonstration projects, the Bundled Payments for Care Improvement (BPCI) program. Under the program, health-care organizations enter into payment arrangements that include a new revenue structure based on financial and performance accountability for entire episodes of care, in this case joint replacements. The program is showing promise for Colorado patients, who are seeing improved outcomes.

There are concerns with the implementation of the program, specifically the National Trend Factor, which continuously updates the target prices set by CMS. Providers have asked for increasing clarity from CMS and CMMI.

As CMS Administrator, how would you address these issues so that providers continue to participate in voluntary demonstration projects that improve outcomes for patients?

Answer. If confirmed, I plan to work to ensure that the Innovation Center—after appropriate consultation with Congress, the States, health-care stakeholders, and Innovation Center staff—address such concerns in testing innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries. I look forward to reviewing current CMMI projects, consistent with congressional actions.

Question. Reforming the Stark Law has been a topic of discussion over the past few years as we move toward alternative payment models that pay for value.

In your role as CMS Administrator, will you recommend updates to Stark Law when alternative payment models are used?

Answer. While there are a number of legitimate concerns regarding physician referrals and compensation, I think it may be appropriate to examine regulations implementing the Stark Law and its impact on reform efforts. In some cases, the Stark Law may discourage coordination of care, and lead to a more fractured health-care system. I would consider these situations closely, in consultation with Congress and in context when considering what changes might be needed. I look forward to working with Congress to implement the law on critical issues related to APMs and the Stark Law.

Question. Current CMS health-reform efforts are based on the concept of the triple aim—improving the patient health-care experience, improving the health of the population at large, and reducing the per capita costs of health care.

If confirmed as CMS Administrator, will the triple aim remain a central tenant of CMS efforts?

What metrics will you use to ensure these goals are met?

Answer. The triple aim includes the goals we all share for our health-care system and, if confirmed, I would work to ensure its elements would remain important to CMS's work. The fundamental metric for knowing that our system is on the right track is the centrality of the patient in the system and their ability to make choices about their care in consultation with their doctor. Without that, the most impressive facilities and technology are not serving our people's needs, nor is the most efficient system doing what is most important. With the patient at the center of the system as a foundation, all else is possible and achievable.

Question. Physicians have noted that the lack of interoperability between electronic health record (EHR) systems has been a key barrier to complying with requirements for meaningful use of health IT.

How do you plan to address the ongoing challenges related to EHR interoperability?

How do you plan on restructuring the incentives for meaningfully using EHRs?

Answer. If confirmed, I look forward to working with Congress to implement laws related to improving the use of EHRs. Patients and providers depend on the fast

exchange of information across health systems. Having access to a patient's complete medical record enables a medical professional to better diagnose and treat a patient. Doctors know best how to treat their patients and we should think of EHRs as a means to enable that better care. As Congress considers options to improve the interoperability of this system so that the burdens on physicians do not hinder their ability to practice medicine, I will stand ready to provide technical assistance and support through that process.

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

Question. Elected officials on both sides of the aisle have said they strongly support the ACA's provision allowing young adults to stay on their parents' insurance until age 26. As you know, there is a parallel provision in Medicaid law allowing youth aging out of foster care to maintain health coverage until they turn 26, given they have no parents to provide that benefit for them.

Do you agree that foster youth—children who were removed from their homes due to abuse and neglect—should have the same Federal health coverage protections as children who are fortunate enough to be able to stay on their parents' health coverage?

Answer. This would be a part of the new legislation that Congress will be voting on, so that decision is in Congress' hands. If confirmed, I will work to ensure that CMS appropriately implements the statutes within its purview.

Question. The Children's Health Insurance Program (CHIP) has been an enormously successful program and has helped, along with Medicaid and the Affordable Care Act, to bring children's insurance rates up to 95 percent—the highest rate ever. The program currently covers about 8 million children per year, is popular, and has enjoyed significant bipartisan support from Congress. It is also due to be reauthorized this year.

Will you pledge to work with Congress to reauthorize and fully fund the CHIP program in a timely manner?

If confirmed, will you guarantee that under your leadership, CHIP will continue to be a viable option for America's children, and that it will continue to cover medically necessary care for the children who are enrolled?

Answer. It is important that every child has access to high-quality health coverage. CHIP plays an important role in accomplishing this objective, but there is also a need to focus on family coverage in the private market and employer plans, and on giving States needed flexibility. Each State has different needs, and I believe CMS needs to work with States to ensure that, consistent with those needs, the CHIP program provides the best possible coverage to their residents. If confirmed, I look forward to working with you on this issue to share feedback and technical assistance on policies relating to CHIP. I will work to implement CHIP reauthorization as passed by Congress.

Question. At the end of last year, the HHS Assistant Secretary for Planning and Evaluation (ASPE) put out a report that I and other members requested on the impact of socioeconomic status (SES) on the Medicare quality programs like hospital readmissions and the Medicare Advantage star ratings. All these ratings either reward or penalize monetarily for good or bad results and those that serve a high number of low SES individuals have a harder time achieving high quality ratings because of the complications of the populations. In this report ASPE discussed options on how to improve the quality programs and more accurately account for these populations.

What do you think we need to do, to improve how Medicare accounts for SES in the quality programs?

Answer. My work with vulnerable populations has highlighted for me the impact of social determinants of health and the role of life choices in managing one's own health. At the end of the day, health-care programs for this population ought to empower and enable ownership of one's health care. If confirmed, we ought to explore ways that SES as well as the way other important factors impact quality programs and design the programs with the goal of ensuing patient empowerment front and center.

Question. Many people with disabilities want to work and can do so with the services only available through Medicaid, to help them work. These services include sup-

ported employment for people with mental health disabilities or personal care attendants for those with intellectual or physical disabilities. Without these services, many people with disabilities will be unable to work.

How will you ensure that a person with a disability, mental health, intellectual, physical, sensory, or any other type of disability as defined by the Americans with Disabilities Act, has access to the services currently available through Medicaid?

Answer. Our goal is to ensure access to affordable, quality health care for all citizens. This, of course, includes people with disabilities who depend on Medicaid. Towards this end, I support the principles of community integration, beneficiary autonomy in decision making, and person-centered planning articulated in CMS's approach to Home and Community Based Services and the HCBS Settings Rule (with a compliance date in March 2019). If confirmed as CMS Administrator, I would rely on these principles in making decisions appropriate to CMS' role in administering Medicaid and working with Congress to implement and support efforts that help people work.

Question. The Center for Medicare and Medicaid Innovation (CMMI) was created to test new payment models and encourage the Medicare and Medicaid programs to look beyond traditional payment systems and find new ways to help individuals benefit from the many advances of modern medicine. These advances have been seen in the clinical setting and in the form of new, innovative therapies, some of which even offer potential cures for diseases that previously could only be managed with chronic therapies.

Would you be willing to work with Congress to develop alternative payment models that test these advances and examine the benefits these advances could have on Medicaid and Medicare beneficiaries, as well as how such alternative payment models could affect the cost of care over a decade or more, and work with Congress to remove any obstacles that might prevent those models from moving forward?

Answer. If confirmed, I plan to work to ensure that the Innovation Center—after appropriate consultation with Congress, the States, health-care stakeholders, and Innovation Center staff—tests innovative models that reduce costs and improve quality for Medicare, Medicaid, and CHIP beneficiaries. I look forward to reviewing current CMMI projects, consistent with congressional actions.

QUESTIONS SUBMITTED BY HON. MARK R. WARNER

Question. Eleven percent of Virginians rely on Medicaid for their health insurance, even without Medicaid expansion. This coverage is more efficient than most other forms of insurance; Virginia also operates the 3rd most efficient Medicaid program in the country, receives the lowest allowable Federal matching rate, and the vast majority of beneficiaries are enrolled in a managed care plan. Block granting or imposing a cap on Medicaid would be damaging to States like Virginia. Do you oppose structural changes to Medicaid that shift costs onto the States like block granting or per capita caps?

Answer. If confirmed as Administrator, I intend to work with States and Congress to improve Medicaid and implement the laws enacted by Congress. From demographic and budgetary concerns to ensuring access for special populations, each State faces different challenges in Medicaid. A one-size-fits-all approach will not work and that is why flexibility for States in how they design their Medicaid programs is crucial. At the same time, States must be held accountable to standards that result in better health-care quality and access. The mechanics of Medicaid reform will be a legislative decision that will need to account for how to encourage States to work together on making improvements to the program while increasing flexibility.

Question. Seventy-seven percent of Virginia Medicaid enrollees are in families where at least one individual is employed, and unfortunately many of the rest are forced to rely on the program not by choice, but because they are unable to work—perhaps requiring child care or job training, or have a disability. The evidence shows that imposing a work requirement actually has a limited impact on employment, especially in the long-term. Do you intend to require States, or make it easier through the waiver process, to include work requirements as a condition to receive Medicaid services? If you were to impose work requirements in Medicaid, would you also commit to supporting those enrollees who need access to child care, transportation, or job training?

Answer. If confirmed, I will coordinate with States to provide greater flexibility for determining how to care for their most needy citizens as we encourage work and opportunity.

Question. Do you agree with President Trump's statement on the campaign trail that he would not reduce Medicare benefits, or make major changes to Medicare outside of eliminating waste, fraud and abuse? Would structural changes to Medicare maintain the basic Medicare guarantee, while also strengthening the program's solvency?

Answer. If confirmed, I will serve at the pleasure of the President and will support his policy initiatives within the bounds of the law. As Congress considers structural changes to Medicare, I will stand ready to provide technical assistance as needed if I am confirmed. Ultimately, the decision whether to enact structural changes to the program is the province of Congress. Whatever reforms are considered, CMS will put the patient first in our implementation of the reform in question.

Question. I have worked with bipartisan members of the Finance committee to expand the use of telehealth, especially in Medicare, which lags most State Medicaid programs and the commercial sector. CMS already has the authority to lower some barriers for telehealth and remote patient monitoring in Medicare without Congress. What actions, especially around alternative payment models such as ACOs, should CMS take to increase the utilization of technology in a way that improves quality while maintaining fiscal integrity? Under what circumstances should fee-for-service Medicare cover telehealth services? What evidence does CMS need to similarly increase access to remote patient monitoring services in fee-for-service Medicare?

Answer. I share your interest in promoting telehealth. Telehealth can provide innovative means of making health care more flexible and patient-centric. Innovation within the telehealth space could help to expand access within rural and underserved areas. If confirmed, I look forward to continued discussions on telehealth, including on the best means to offer patients increased access, greater control and more choices that fit their medical needs.

Question. Despite the ACA lowering the percentage of uninsured by 8 percentage points in rural counties, rural hospitals are still facing immense challenges, serving older, sometimes more economically disadvantaged populations challenged by less access to primary, dental, and family health care than their urban counterparts. CMS threatened to reclassify Page Memorial Hospital in Luray so that it would no longer serve as a Critical Access Hospital, which would have effectively led to the hospital significantly reducing services such as treatments for heart disease and diabetes, which occur in Page County at far higher rates than statewide. I worked with CMS to ensure that Page kept its Critical Access Hospital classification As CMS Administrator, what improvements to the hospital classification system will implement to ensure that Critical Access Hospitals like Luray are adequately funded?

Answer. As you may be aware, roughly one-third of America's counties now have only one health insurer offering coverage on the individual market Exchange. The problem is especially acute in rural counties, as insurers continue to exit the market and costs continue to rise, making coverage less affordable and reducing choices for patients. Moving forward, our goal must be to ensure every American has access to the coverage they need, including those who access care at rural or Critical Access Hospitals. I believe the best metric in the end is one that measures the extent of access to care rather than simply looking at coverage. If confirmed, I look forward to working with CMS staff to evaluate the hospital classification system and to understanding the unique issues for your State and its hospitals.

Question. The Obama administration made significant progress to better align fee-for-service Medicare payments with value and quality, and I have spent the better part of 2 years working with bipartisan members of this committee to improve care for Medicare beneficiaries with chronic illness. In what sector of the Medicare program will you focus on accelerating value-based purchasing or the broader move to align with value and quality?

Answer. If confirmed, I plan to evaluate the respective sectors of the Medicare program to understand how payment reforms are working—or not working—for providers and their patients, especially as we implement MACRA in accordance with the law. Measuring value and quality is a challenge that requires careful planning and broad collaboration among all involved stakeholders, especially the beneficiaries who are impacted most.

Question. By moving toward a consolidated quality-reporting and payment system under MACRA, Physicians are incentivized through payment adjustments into alternative payment models, and those who remain in fee-for-service report on quality, resource use, clinical practice improvement, and use of electronic health records. Which of these metrics do you expect to be most challenging for providers to meet, and how quickly would you anticipate payment adjustments moving providers into alternative payment models?

Answer. For small providers, especially in rural Virginia and other rural locations around the country, change can be difficult. The implementation challenges created by new government-directed programs are different and oftentimes more significant for smaller health-care providers than they are for larger providers who might have the resources and personnel to handle such changes. As we move forward with the implementation of MACRA it is critical that we collaborate and communicate with all providers on the frontlines to better understand what challenges they are facing and how we can support them through its implementation.

Question. The Obama administration made significant progress to better align fee-for-service Medicare payments with value and quality, and I have spent the better part of 2 years working with bipartisan members of this committee to improve care for Medicare beneficiaries with chronic illness. The Annual Wellness Visit, or AWV, is an important preventative benefit for Medicare beneficiaries. One of the key required components of this visit is an assessment of the beneficiary's cognitive functioning, which could be particularly useful in detecting early signs of Alzheimer's or other forms of dementia, helping beneficiaries receive a timely diagnosis and access additional services and supports, like the new assessment and care planning services for beneficiaries. Despite existing for 6 years, as of last year fewer than 20 percent of Medicare beneficiaries utilized the Annual Wellness Visit. What concrete steps will CMS take to increase access to the Medicare Wellness Visit?

Answer. If confirmed, I look forward to working with you to enable better access to preventative care for Medicare beneficiaries. First, we should evaluate what is working well and what the areas are for improvement. Your counsel as we move forward in evaluating the AWV will be critical.

Question. Effectively caring for patients at all stages of illness is an important part of moving Medicare into the 21st century. I have worked with Senator Isakson and others to ensure that conversations between patients and the care team help patients to navigate this difficult process: improvements to care planning would give individuals and their families the ability to make smarter decisions, and provide information and support so they can make informed choices based upon their own values and goals. One CMMI demonstration provides hospice beneficiaries with the option to receive supportive care services typically provided by hospice while continuing to receive curative services, called Medicare Care Choices. What additional steps would you take to expand timely access to concurrent curative care and hospice services? What other steps would you explore to expand access to hospice and palliative care?

Answer. As you know, the Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness, including drugs and medical and support services. Under the current structure, hospice care is provided in lieu of most other Medicare services related to the curative treatment of the terminal illness. Through the Medicare Care Choices Model, the Innovation Center is piloting a new option for Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers. Should I be confirmed as Administrator, I intend to carefully examine this Innovation Center model as well as look at other options for expanding access to hospice and palliative care.

Question. The Center for Medicare and Medicaid Innovation (CMMI) is conducting several demonstration projects for alternative payment models in Medicare with the potential to save taxpayer dollars while maintaining or improving the quality of care for beneficiaries, including bundled payments for cardiac care, competitive bidding and value-based insurance design. With a voluntary approach, only those who are already efficient or performing well may participate. Out of the over 75 CMMI demonstrations, which 2 do you think have the most potential to improve care and lower cost? Please specify two additional demonstrations you would plan to build upon, if confirmed as CMS Administrator?

Answer. The Innovation Center provides significant opportunity for testing new models for health-care financing and delivery. I cannot comment on specific dem-

onstrations at this time, without examining the outcome data. However, if confirmed, I intend to examine the range of demonstrations currently underway, as well as look for potential new initiatives to explore innovative approaches to lower health-care costs and improve quality for Medicare and Medicaid beneficiaries. I look forward to reviewing current CMMI projects, consistent with congressional actions.

Question. The Affordable Care Act included many provisions with budget savings, including increased revenue and Medicare savings. Fully repealing the Affordable Care Act, including revenue provisions and Medicare savings, would add significantly to the national debt, cost $350 billion over 10 years under conventional scoring, and hasten Medicare's insolvency by 5 years. Are you in favor of an ACA repeal that will contribute to our national debt and deficit? Do you believe the revenues in ACA, much of which funded the coverage expansion, should be retained, set aside for a possible replacement, or fully repealed?

Answer. Should I be confirmed as Administrator of CMS, my duty will be to execute the law as passed by Congress and signed by the President. This includes ensuring that the Medicare program is well administered, effective, and available for eligible beneficiaries, and that it is sustainable for the future.

Question. While we are moving towards paying for value in many areas of health care, in the drug space we have largely lagged behind. In the past year, some insurers and drug manufacturers piloted value-based arrangements that hold the manufacturer accountable for how their product performs in the real world on an agreed upon set of metrics. In 2015, I was the lead author of a letter to CMS asking them to examine the potential of using value-based arrangements in Medicare and other public programs. Will you commit to working with me to identify potential policy barriers that Congress should review in order to move towards reimbursement for value rather than volume in the drug space?

Answer. If confirmed, I look forward to working with you and providing technical assistance, when appropriate, as Congress considers legislation that impacts CMS and the beneficiaries served by Medicare and Medicaid.

Question. As Governor of Virginia, I prioritized the Commonwealth's Children's Health Insurance Program (FAMIS), and streamlined the program so that it could fund coverage for 200,000 Virginia children each year, almost 98% of eligible children. ACA repeal could result in the loss of $114 million from Virginia's Children's Health Insurance Program, and increase the uninsured rate among Virginia kids from 3% to 8%. Block granting or capping Medicaid would also damage the Commonwealth's ability to cover children, who represent half of Virginia Medicaid enrollees but only 20% of costs. Will you support any policy, regulation, or proposal that would increase the uninsured rate among children?

Answer. It is important that every child has access to high-quality health coverage, and CHIP plays an important role in accomplishing this objective. CHIP plays a major role in this, but there is also a need to focus on family coverage in the private market and employer plans, and giving States needed flexibility. Each State has different needs, and I believe CMS needs to work with States to ensure that, consistent with those needs, the CHIP program provide the best possible coverage to their residents. If confirmed, I would work with Congress on CHIP reauthorization with these principles in mind.

QUESTION SUBMITTED BY HON. MARK R. WARNER AND HON. JOHNNY ISAKSON

Question. Over the past 3 decades, rural hospitals in Virginia and Georgia have lost out on millions of dollars of Medicare payments annually because of this skewed wage index formula. I worked with Senator Isakson and others to help rural hospitals in many parts of the country receive fair Medicare reimbursement, by introducing the bipartisan Fair Medicare Hospital Payments Act. The bill would level the playing field for at least 19 hospitals in rural Virginia and over 100 in Georgia. As CMS Administrator will you work with us to correct the gaming of the Medicare wage index, and ensure that we shore up rural hospitals nationwide?

Answer. If confirmed as Administrator, I intend to examine the impact of the statutory wage index, as well as the range of issues facing Medicare, as we look for ways to improve the program and make it sustainable for the future.

QUESTIONS SUBMITTED BY HON. CLAIRE MCCASKILL

Question. Before the passage of the ACA, it was legal for insurers in some States to use being a survivor of domestic violence as a pre-existing condition.

Do you have a plan to ensure that survivors of sexual assault have access to affordable comprehensive insurance coverage and that they are not subject to discrimination or higher prices?

Answer. No one should have to pay higher health insurance rates due to being a victim of domestic violence or sexual assault. If confirmed, I look forward to taking steps to increase access to affordable, quality health care for all Americans, including those who are victims of domestic violence or sexual assault.

Question. Do you believe that the Federal Government should have access to State data in order to perform evaluations of the Medicaid program generally and Medicaid demonstration projects specifically?

Answer. If confirmed, I will work within the confines of the law to partner with States to exchange appropriate data in order to evaluate and improve our health care delivery systems. I am a strong proponent of State innovation and flexibility—and States must also be held accountable for ensuring the programs they operate provide access to high-quality care.

Question. Earlier this month, the CDC released data showing that the uninsured rate was 8.8 percent for the first 9 months of 2016, which was a historic low.

Will you advise against measures that increase the number of people without insurance?

Answer. I have fought for coverage and greater access to health care throughout my career. If confirmed, I will work with you and your office, the Congress and all interested parties to increase access to high-quality health care. However, we should not assume that just because people have an insurance card that they have access to health care. Many people have out of pocket expenses they cannot afford and others face limitations on the providers they can see. If confirmed, I will do everything I can to ensure that coverage results in better access to care.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The health-care post the Finance Committee is going to discuss this morning might not be dinner-table conversation, but it's one of the most consequential roles in American government—the Administrator of the Centers for Medicare and Medicaid Services.

CMS is responsible for the health care of over 100 million Americans who count on Medicare and Medicaid. It also plays a big role in implementing the ACA. That's a weighty responsibility, and that's why CMS needs the most experienced and qualified people for the job—people who know the ins and outs of health-care policy across the entire system: Medicare, Medicaid, and the private insurance market.

CMS needs to have a strong and experienced authority on policy at a time when many in the administration, as well as some of my colleagues on Capitol Hill, are pushing to make radical changes to America's health-care system. In my view, many of these proposals would take the country back to the days when health care was mostly for the healthy and the wealthy. I'll be listening closely to see if Ms. Verma is up to the task.

I'd like to start off with the promise of Medicare—the promise of guaranteed health benefits for seniors. Medicare makes up more than half of CMS's spending—roughly $2.2 billion a day. With more seniors entering the program every year, there's a lot of work that needs to be done to protect and update the Medicare guarantee for the 21st century.

Updating Medicare means addressing the high and rising cost of prescription drugs that are putting a big time strain on seniors' budgets. It means making the program work better for people who have to manage multiple chronic diseases, like heart disease, cancer, diabetes and stroke that constitute the vast majority of the Medicare dollar today. Those are the kind of bipartisan concerns Congress and CMS should be collaborating on.

Privatizing Medicare is the wrong direction for people across the country who expect the program to be there for them in their later years. I want to hear how Ms. Verma's views differ from those of the policymakers, including now-Secretary Price, who want to turn the entire program into a voucher system.

Additionally, if confirmed, Ms. Verma will play a key role in implementing the bipartisan Medicare physician payment reforms. It's essential that she implement the law as intended by Congress as America's health-care system continues the long-needed shift from paying for volume to paying for value.

CMS also implements and oversees the rules of the road in the private insurance market established by the ACA. Today, many of those rules amount to bedrock values for health insurance in America:

- Not discriminating against those with pre-existing conditions no matter what;
- Setting the bar for what type of medical care insurance companies must cover; and
- Letting young adults keep their parent's insurance until 26.

However, just yesterday, CMS released a proposed rule affecting insurance coverage next year. From where I sit, the message from that rule is clear: insurance companies are back in charge, and patients are taking a back seat. The open enrollment period was cut in half, from 3 months to 6 weeks. If someone dropped coverage during the year for any reason, insurance companies could collect back-premiums before an individual is able to get health insurance again. And insurance companies will have free reign to offer less generous coverage at the same or higher costs. All of this sounds to me like a step backward towards health care only for the healthy and wealthy.

This administration has been saying—on repeat—that the best is yet to come, but the evidence suggests otherwise. The President could have taken steps to create more stability on a bipartisan basis, but instead issued an Executive order on the day he was sworn in that is creating market uncertainty and anxiety. You don't need to look further than Humana's recent decision to leave the market to see that confidence in the President's promise is low.

So it will be important to hear from Ms. Verma this morning about how she plans to implement this program that millions of Americans count on as Republicans in Congress actively discuss, even today, how they will begin to unravel the law. I hope Ms. Verma will use her position if confirmed to move beyond the tired "repeal and run" ideas that look increasingly impossible.

The repeal and run scheme goes beyond disrupting the individual market. It would also end the Medicaid expansion that has brought millions of low-income, vulnerable Americans into the health-care system, many for the first time in their lives. This is the area where Ms. Verma has had most of her health-care experience. The project she is known best for is what's called "Healthy Indiana 2.0," which expanded Medicaid in her home State.

The tradeoff for that expansion is something I'd like to focus on in more detail. I'm particularly concerned about the possibility that someone making barely $12,000 dollars a year would get locked out of health coverage for no less than 6 months because they couldn't pay for health care due to an upcoming rent check, for example, or an emergency car repair.

According to an independent evaluation commissioned by the State of Indiana, more than 2,500 people were bumped from coverage due to a situation like this. I'm also concerned about data from the same report that found more than 20,000 people were pushed onto a more expensive, less comprehensive Medicaid plans because they couldn't pay or navigate the complicated system Ms. Verma put in place. These complex rules apply no matter your situation: homeless, suffering from a mental health crisis, or without a regular income, to name a few.

I have great reservations about taking these questionable ideas on a nationwide tour. Flexibility for States to pursue policies that work well for them is something I've always championed. But I'm in favor of flexibility for States when it helps them do better, not when it helps them do worse. I'm proud to say my home State has one of the leading Medicaid programs in the country—and it just got a renewed waiver. States should not be denied the opportunity to do what they want because they don't pursue policies like Indiana's.

However, Ms. Verma will not only be responsible for the 11 million individuals who gained coverage under the expansion, but also for the 60 plus million Americans who rely on Medicaid: to help pay for nursing and home-based care; to provide comprehensive coverage for one out of three children; and to help people live healthy lives in their communities. All of them are at risk under Republican proposals to slash the social safety net through block grants or caps.

Before I wrap up, I'd like to discuss one more issue that relates to Ms. Verma's work in Indiana. Ms. Verma and her consulting firm were awarded more than $8.3 million in contracts directly by the State of Indiana to advise the State and help manage its health-care programs. In effect, she was the policy architect. At the same time, she contracted with at least five other companies that provided hundreds of millions of dollars of services and products to those very programs—HP Enterprises, Milliman, Inc., Maximus, Health Management Associates (or HMA), and Roche Diagnostics. In the case of at least two of these firms—HP and HMA—the terms of her State contracts appear to have had her directly overseeing work these firms performed.

Instead of offering my own views on this arrangement, I'll quote President George W. Bush's ethics lawyer Richard Painter, hardly a liberal, who yesterday said that this arrangement, quote, "clearly should not happen and is definitely improper." Ms. Verma is on both sides of the deal, helping manage state's health programs while being paid by vendors to those same programs. Richard Painter called that a "conflict of interest." I agree.

These companies she consults with—HP, Maximus, Milliman, and HighPoint Global—also work with CMS, which she'd be running if confirmed. While her ethics agreement specifically requires recusal with regard to HMA, it does not specifically address the question of her recusal obligations with regard to these other companies.

I think the committee has an obligation to find out more about Ms. Verma's work for companies that did business with the State while she worked for the State. Senators also need to be assured that if she becomes the CMS Administrator, she will recuse herself from decisions that affect the companies that were her clients.

Ms. Verma, I thank you for joining the committee this morning, and I appreciate your willingness to serve. I look forward to your testimony.

