DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2021 BUDGET

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2021 BUDGET

WEDNESDAY, MARCH 4, 2020

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room 210, Cannon House Office Building, Hon. John A. Yarmuth [Chairman of the Committee] presiding.

Present: Representatives Yarmuth, Moulton, Higgins, Schakowsky, Morelle, Horsford, Jackson Lee, Jayapal, Khanna; Womack, Woodall, Johnson, Smith, Flores, Holding, Stewart, Norman, Hern, Roy, Meuser, and Burchett.

Chairman YARMUTH. Good morning. I want to welcome everyone to this hearing on the Department of Health and Human Services' Fiscal Year 2021 Budget. And I certainly welcome the Deputy Secretary for the Department of HHS, Eric Hargan.

Thank you for being here today. I now will yield myself five minutes for an opening statement.

Deputy Secretary Hargan, the importance of the Department of Health and Human Services cannot be overstated. But now, amid the deadly coronavirus outbreak, the work of HHS has unmatched importance. Strategic investments in public health systems, research into a vaccine and treatments, availability of accurate testing, and access to high-quality care are critically important.

But the contrast between those needs and the Trump Administration's budget could not be more stark. Instead of proposing a realistic budget for HHS and taking the health and well-being of Americans seriously, the President has called for draconian cuts, mounted consistent attacks on our health care, undermined the agencies charged with keeping us safe, and starved our communities of critical resources.

President Trump has proposed a nearly $10 billion cut to HHS's discretionary budget, including debilitating cuts to the CDC and NIH. He slashes mandatory health care spending by $1.6 trillion over 10 years, including a $900 billion cut to Medicaid, a half-a-trillion-dollar cut to Medicare, and a $200 billion cut to other health programs.

The budget would require all states to enact work requirements for Medicaid enrollees with no exceptions for pregnant women, parents, the chronically ill, and other vulnerable Americans. This comes despite the fact that no evidence exists to support the Ad-

ministration's claim that they increase the financial well-being of Medicaid enrollees.

The Administration's real goal here, it appears, is to create yet another barrier so that hundreds of thousands, if not millions, of Americans lose their Medicaid coverage, and now at the worst possible time.

That is not the only way this budget makes life harder for millions of families. It includes the elimination of block grants and programs like LIHEAP that help working families fight their way out of poverty.

Despite the President's promise to prioritize child care, any investments made in this budget would be nullified by the complete elimination of the Social Services Block Grant and the Community Services Block Grant, and the $21.3 billion cut to the Temporary Assistance for Needy Families program.

There are other areas of the budget that don't add up, either, where the message doesn't match the math. The budget includes a $716 million investment in HIV/AIDS, but cuts important NIH research programs dedicated to HIV prevention and treatment by 8 percent. It also cuts programs to treat global HIV/AIDS by $2 billion, or 35 percent.

The budget requests $169 million in new resources to combat the opioid epidemic, but these nominal investments are negated by the nearly $900 billion cut to Medicaid, the source of coverage for four in 10 adults with opioid addiction.

When you compare these small funding increases to the huge cuts that they are paired with, it is not hard to see them for what they are: token investments designed to get a good headline. If there is another explanation, Deputy Secretary Hargan, we would welcome it.

We would also welcome some details on the President's so-called vision for American health care, since there are none in this budget, nothing specific about the President's so-called commitment to lowering prescription drug prices, nothing about expanding access to affordable, quality health care. It is nothing but a vague promise.

There are many troubling parts of this budget, particularly since the line between massive HHS funding cuts and severe consequences for American families, between policy changes and life-or-death outcomes, is so direct.

But, look, this is not a normal budget hearing. We are potentially facing a public health crisis like we haven't seen in years. And, from everything I have seen, this President doesn't get that. He sought to under-fund or eliminate programs to respond to public health emergencies from the get-go. Two years ago he fired the government's entire pandemic response chain of command and never replaced them. He told the American people that the virus was largely contained. Then he said it will go away in April, when temperatures warm up. Both aren't true. He proposed a woefully inadequate coronavirus supplemental that cannibalized other programs, playing a dangerous game of public health whack-a-mole.

And the President's budget has no shortage of broken promises, harsh cuts, and cruel policies that place little importance on public

health, and jeopardize the health care security of millions of Americans. Our President is clearly not up to the task.

But, Deputy Secretary, I hope you have more to offer the American people today. I hope you are able to help reassure all of us that our government is on top of this, that the doctors and scientists who really know what they are doing are making the decisions, and that everything is being done to protect the American public. We look forward to your testimony, your response to these concerns, and getting some sort of justification for the decisions made in this budget.

[The prepared statement of Chairman Yarmuth follows:]

Chairman John A. Yarmuth
Hearing on the Department of Health and Human Services FY 2021 Budget
Opening Statement
March 4, 2020

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That's not the only way this budget makes life harder for millions of families. It includes the elimination of block grants and programs like LIHEAP that help working families fight their way out of poverty. Despite the President's promise to prioritize childcare, any investments made in this budget would be nullified by the complete elimination of the Social Services Block Grant and the Community Services Block Grant, and the $21.3 billion cut to the Temporary Assistance for Needy Families program.
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Chairman YARMUTH. And with that I yield five minutes to the Ranking Member.

Mr. WOMACK. I thank the Chairman for holding this hearing.

Thank you, Mr. Deputy Secretary, for your witness testimony here today.

Today we examine the President's budget request for the Department of Health and Human Services for Fiscal Year 2021, an important conversation, in my judgment, and one that we are having because the President, unlike my colleagues on the other side of the aisle, actually produced a budget.

The primary responsibility of this Committee is to put forth a budget resolution. In fact, it is required by law. Yet, for the second year in a row, this Committee has abdicated on its responsibility. I know there will be plenty of discussion today, but I hope my colleagues will remember that political commentary won't change the important issues we need to address.

With that said, let's turn to the President's budget request for HHS for this fiscal year.

HHS is responsible for administering programs from which millions of Americans—on which millions of Americans rely, including Medicare, Medicaid, TANF, and Head Start. You are also charged with addressing some of the country's biggest health crises, including coronavirus.

The agency also faces several budgetary challenges that must be addressed: the ever-ballooning cost of prescription drugs, the solvency of the Medicare Trust Fund, and the untenable spending trajectory of Medicaid.

Health care spending is growing faster than any other sector of our economy. In 2018 the U.S. spent $3.6 trillion on health care. By 2027, health care spending is projected to reach nearly $6 trillion, just under 20 percent of America's GDP, according to a recent report from the Centers for Medicare and Medicaid Services' actuary. Congress has to pay attention to the factors that are fueling this growth.

First, the cost of care is increasing. According to the Bureau of Labor Statistics, in 2019 the price of hospital services increased by 3.8 percent, and the price of medical care increased by 5.1 percent, both of which are higher than the rate of inflation.

Second, Americans are living longer. Thanks to advancements in modern medicine, the average life expectancy has increased by roughly nine years since Medicare was created in 1965. Now, that is good news, but it does have an impact on the growing health care issues facing our country.

Finally, the ratio of retirees to workers is shrinking. That is not good news. An average of 10,000 Baby Boomers are leaving the work force every day.

Unfortunately, the laws that govern how our health care programs work have not kept pace with these realities. As a result, there is increasing pressure on programs like Medicare, which provides care to about 18 percent of our population. As an example, Medicare Part A, which covers in-patient hospital care, skilled nursing facilities, hospice, and lab tests, is expected to be insolvent by 2026, threatening the health benefits many people expect to receive in the future. That is only six years away.

Congress and the Administration have a shared responsibility to address these challenges and put our health care spending back on a sustainable path. I would argue that Congress and the Administration not only have a shared responsibility, that is our only hope. That requires taking a hard look at what is working and what is not. It requires the fortitude to make tough choices that strengthen programs for today and tomorrow.

The President's budget takes important steps to do that. It invests in the long-term health of the American people, while also advancing proposals that will help rein in health care spending. For example, it doubles down on the addressing—on addressing the opioid epidemic by bolstering the SUPPORT Act, which expands across to substance use disorder prevention and treatment. Additionally, it includes new resources to expand state opioid response grants that provide direct treatment, recovery, and relapse prevention. It also supports our commitment to decreasing the number of people affected by HIV, by making vital investments in programs aimed at reducing new infections by 90 percent within a decade.

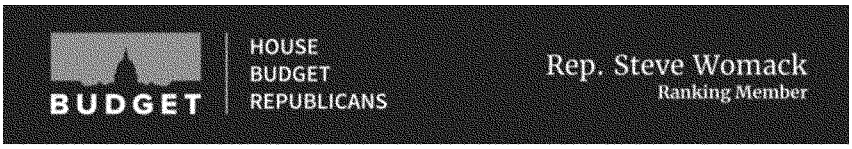
At the same time, the budget includes several common-sense reforms that have been proposed by both Republicans and Democrats to make Medicare work better for patients, by cutting waste, fraud, and abuse, increasing competition, and lowering drug prices and out-of-pocket costs. These comprehensive efforts are poised to achieve roughly $1.7 trillion in savings in mandatory spending. That is important progress, but with $23 trillion in debt, and annual deficits over $1 trillion, there is much more work that has to be done.

As I have said before, mandatory spending accounts for 70 percent of all federal spending today, and it is on a glide path to go to 76 percent by 2030. Until we make structural reforms to mandatory spending programs like Medicare, discretionary spending, including funds for defense and other key domestic priorities—and let me add, priorities that are equally important to both sides of the aisle—are going to continue to be squeezed.

Congress will continue to have the same battles year after year over what programs to fund, and how to handle our deficit and debt. Instead of it recognizing these fiscal realities, my colleagues on the other side of the aisle continue to propose bills like Medicare for All, which would radically disrupt our health care system.

So I look forward to your testimony today, Mr. Deputy Secretary. I again thank my friend from Kentucky for holding this hearing, and I yield back the balance of my time.

[The prepared statement of Steve Womack follows:]



Ranking Member Steve Womack (R-AR)

Opening Statement at Hearing Titled:

"Department of Health and Human Services

Fiscal Year 2021 Budget"

Remarks as prepared for delivery:

Thank you, Chairman Yarmuth, for holding this hearing, and thank you, Deputy Secretary Hargan, for joining us.

Today, we will examine the President's budget request for the Department of Health and Human Services for fiscal year 2021. It's an important conversation, and one we are having because the President—unlike my colleagues on the other side of the aisle—produced a budget.

The primary responsibility of the House Budget Committee is to put forth a budget resolution. In fact, it's required by law. Yet, for the second year in a row, this Committee has abdicated its responsibility. I know there will be plenty of discussion today – but I hope my colleagues will remember that political commentary won't change the important issues we need to address.

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First, the cost of care is increasing. According to the Bureau of Labor Statistics, in 2019, the price of hospital services increased by 3.8 percent, and the price of medical care increased by 5.1 percent – both of which were higher than the rate of inflation.

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Finally, the ratio of retirees to workers is shrinking, with an average of 10,000 baby boomers leaving the workforce every day.

Unfortunately, the laws that govern how our health care programs work have not kept pace with these realities. As a result, there is increasing pressure on programs like Medicare, which provides care to approximately 18 percent of our population.

For example, Medicare Part A – which covers inpatient hospital care, skilled nursing facilities, hospice, and lab tests – is expected to be insolvent by 2026, threatening the health benefits many people expect to receive in the future. That is only six years away.

Congress and the administration have a shared responsibility to address these challenges and put our health care spending back on a sustainable path.

That requires taking a hard look at what's working and what's not. It also requires the fortitude to make tough choices that strengthen programs for today and tomorrow.

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These comprehensive efforts are poised to achieve roughly $1.7 trillion of savings in mandatory spending. That's important progress - but with $23 trillion in debt and annual deficits over $1 trillion, there is much more work to do.

As I've said before, mandatory spending accounts for 70 percent of all federal spending today and will rise to 76 percent by 2030.

Until we make structural reforms to mandatory spending programs like Medicare, discretionary spending – including funds for defense and other key domestic priorities – will be squeezed. Congress will continue to have the same battles year after year over what programs to fund and how to handle our debt.

And, instead of recognizing these fiscal realities, my colleagues on the other side of the aisle continue to propose bills like Medicare-for-All, which would radically disrupt our health care system, eliminate patient choice, and add trillions to our national debt.

I look forward to hearing more from you, Deputy Secretary Hargan, as we work through these questions in Congress.

With that, Mr. Chairman, thank you again, and I yield back.

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Chairman YARMUTH. I thank the gentleman for his opening statement and for—in the interest of time, if any other Members have opening statements, you may submit those statements in writing for the record.

And now, once again, I am happy to introduce Deputy Secretary of the Department of HHS, Eric Hargan.

And I yield five minutes to you for your opening remarks.

STATEMENT OF HON. ERIC D. HARGAN, DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HARGAN. Thank you, Chairman Yarmuth and Ranking Member Womack. Thank you again for inviting me to discuss the President's budget for HHS for Fiscal Year 2021. I am honored to appear before this Committee for budget testimony as deputy secretary for the second time, especially after the remarkable year of results that the HHS team has produced.

With support from Congress this past year, we saw the number of drug overdose deaths decline for the first time in decades; another record year of generic drug approvals from FDA; and historic drops in Medicare Advantage, Medicare Part D, and exchange premiums.

The President's budget aims to move toward a future where HHS programs work better for the people we serve, where our human services programs put people at the center, and where America's health care system is affordable, personalized, puts patients in control, and treats you like a human being, not a number.

HHS has the largest discretionary budget of any non-defense department, which means that difficult decisions must be made to discretionary spending on a sustainable path. The President's budget proposes to protect what works in our health care system and make it better. I will mention two ways we do that: first, facilitating patient-centered markets; and second, tackling key impactable health challenges.

The budget's health care reforms aim to put the patient at the center. It would, for instance, eliminate cost sharing for colonoscopies, a lifesaving preventive service. We would reduce patients' costs and promote competition by paying the same for certain services, regardless of setting.

The budget endorses bipartisan, bicameral drug pricing legislation, and the overall reforms will improve Medicare and extend the life of the hospital insurance fund for at least 25 years.

We propose investing $116 million in HHS's initiative to reduce maternal mortality and morbidity.

To tackle America's rural health crisis, which is of particular interest to me, as someone who grew up in rural southern Illinois, we propose reforms, including telehealth expansions and new flexibilities for rural hospitals.

The budget increases investments to combat the opioid epidemic, including SAMHSA State Opioid Response Program, which we focused on providing medication-assisted treatment, while working with Congress to give states flexibility to address stimulants like methamphetamines.

We request $716 million for the President's initiative to end the HIV epidemic in America, which we have already begun implementing with Congress's support.

The budget also reflects how seriously we take the threat of other infectious diseases, such as COVID–19. It prioritizes CDC's infectious disease programs, raising spending on them by 135 million from Fiscal Year 2020 levels to $4.3 billion, and maintains $675 million in state and local preparedness funding. As of this morning we have 78 cases of the novel coronavirus here in the United States, excluding cases that have been repatriated here.

As President Trump, Vice President Pence, Secretary Azar, and all our public health leaders have emphasized, the general risk to the American public remains low, in significant part because of the President's decisive actions so far. But that, as we have emphasized repeatedly, has the potential to change quickly, and the risk can be higher for those who may have been exposed to cases here or who have been to affected areas. We are working closely with state, local, and private-sector partners to prepare for the potential need to mitigate the virus's spread in the United States.

As you all know, OMB has sent a request to make funding available for preparedness and response, including for therapeutics, for vaccines, personal protective equipment, state and local support, and surveillance. The President has made clear that we are open to your views on the levels of spending that may be appropriate. With Secretary Azar serving as Chairman of the president's coronavirus task force, we look forward to working alongside the Administration's lead for the virus, Vice President Pence, to secure the necessary funding from Congress.

Last, when it comes to human services, the budget cuts back on programs that lack proven results, while reforming programs like TANF to drive state investments and supporting work, and the benefits it brings for well-being. We continue the Fiscal Year 2020 investments Congress made in Head Start and child care programs, which promote children's well-being and adults' independence.

This year's budget aims to protect and enhance Americans' well-being, and deliver Americans a more affordable, personalized health care system that works better, rather than just spends more. Secretary Azar and I look forward to working with this committee to make that common-sense goal a reality.

Thank you.

[The prepared statement of Eric D. Hargan follows:]

Deputy Secretary Hargan Written Budget Testimony

The President's Fiscal Year (FY) 2021 Budget (Budget) is built around a vision for HHS and a vision for American healthcare. We are building toward a future where HHS's programs work better for the people we serve; where America's healthcare system is affordable, personalized, and puts patients in control; and where our human services programs put people at the center.

The Budget reflects the Administration's commitments to delivering on this vision and other important themes of HHS's work: advancing a patient-centered healthcare system, protecting the lives of the American people, promoting independence, and making HHS the healthiest organization it can be.

Over the past year, under President Trump's leadership, the men and women of HHS have delivered remarkable results. Beginning in 2018 and through 2019, the number of drug overdose deaths in America began to decline for the first time in nearly two decades, thanks to huge expansions, assisted by HHS, in access to evidence-based addiction treatment. The Food and Drug Administration (FDA) approved a record number of generic drugs and biosimilars in FY 2019. We launched new payment models in Medicare that pay for health and outcomes, rather than sickness and procedures. We finalized a requirement, effective January 2021, that hospitals provide patients with useful price information, and proposed measures to give patients control over their own health data through interoperability. We launched President Trump's initiative to end the HIV epidemic in America within ten years, and worked with Congress to secure funding for it. The Department played a vital role in responding to an Ebola outbreak in the eastern Democratic Republic of the Congo and the humanitarian crisis in Latin America. We took unprecedented steps to expand access to treatment for Americans with serious mental illness and worked to help seniors remain in their homes. The latest data from the Administration for Children and Families shows a record number of adoptions with child-welfare-agency involvement, and reductions in the number of children entering foster care. The Budget proposes to continue work on these priorities, while also identifying new areas for action, such as maternal and rural health.

The Budget proposes $94.5 billion in discretionary budget authority and $1.3 trillion in mandatory funding. Within our discretionary programs, it prioritizes funding for programs that have demonstrated effectiveness, proposes to end programs that have not, and focuses on direct services provided to the American people. On mandatory spending, the Budget proposes commonsense reforms that will pave a path to fiscal sustainability and make these important programs work better for the people they serve.

FACILITATE PATIENT-CENTERED CARE

Providing Price and Quality Transparency

President Trump's Executive Order on *Improving Price and Quality Transparency in American Healthcare to Put Patients First* directs HHS to make healthcare prices transparent, laying the foundation for a patient-driven and value-based health system. HHS has acted swiftly to require hospitals to publish the prices they negotiate with insurers and is working to do the same for issuers, so patients can understand their own out-of-pocket costs. CMS has also required Part D

prescription drug plans to develop tools that allow beneficiaries to determine plan benefits and formularies.

The Executive Order calls for the development of a Health Quality Roadmap that aligns and improves reporting on data and quality measures across Medicare, Medicaid, the Children's Health Insurance Program, and other Federal health programs. The Roadmap will include a strategy for establishing, adopting, and publishing common quality measures; aligning hospital inpatient and hospital outpatient measures; and eliminating low-value or counterproductive measures.

HHS legislative proposals increase price and quality transparency in Medicare. For instance, the Budget would eliminate coinsurance or copayments for a screening colonoscopy when a polyp is found, saving lives and supporting the President's policy to reduce out-of-pocket costs for this common procedure.

The Budget also invests funding in programs that promote transparency. The Budget requests $51 million for the Office of the National Coordinator for Health IT, which includes funding to develop, promote, and adopt common standards to integrate health information and product transparency while protecting privacy. In addition, the new National Institute for Research on Safety and Quality within the National Institutes of Health (NIH) supports the Administration's efforts to move healthcare organizations from volume to value by focusing on improving outcomes, reducing cost, and expanding choices for consumers. Research investments will focus on developing knowledge, tools, and data needed to improve the healthcare system.

Lowering the Cost of Prescription Drugs

The United States is first in the world in biopharmaceutical investment and innovation. But too often, this system has not put American patients first. We have access to the greatest medicines in the world, but access is meaningless without affordability. The Budget supports quick Congressional action to pass comprehensive legislation to address these flaws in our current drug pricing system and provide needed relief to the American people.

The Budget delivers on President Trump's promise to bring down the high cost of drugs and reduce out-of-pocket costs for American consumers by pursuing policies that align with the four pillars of the President's *American Patients First Blueprint*: increased competition, better negotiation, incentives for lower list prices, and lowering out-of-pocket costs.

The Budget includes an allowance for bipartisan drug pricing proposals. The Administration supports legislative efforts to improve the Medicare Part D benefit by establishing an out-of-pocket maximum and reducing out-of-pocket costs for seniors. The Administration also supports changes to bring lower cost generic and biosimilar drugs to patients. These efforts would increase competition, reduce drug prices, and lower out of pocket costs for patients at the pharmacy counter.

The Budget includes an allowance for savings of $135 billion over ten years to support the President's commitment to lower the cost of prescription drugs.

Protecting and Improving Medicare for our Nation's Seniors
Over 60 million American seniors are in the Medicare program, and they are overwhelmingly satisfied with the care they receive through traditional Medicare and Medicare Advantage. The President is continuing to strengthen and improve these programs.

The Budget continues to implement the President's Executive Order on *Protecting and Improving Medicare for Our Nation's Seniors*, building on those aspects of the program that work well, while also introducing market-based approaches to Medicare reimbursement. The Administration seeks to protect and reform Medicare with proposals that strengthen fiscal sustainability and deliver value to patients. To drive reform, the Centers for Medicare & Medicaid Services (CMS) is modernizing the Medicare Advantage program, unleashing innovation, expanding telehealth options, and driving competition to improve quality among private Medicare health and drug plans. The Administration is expanding flexibility for these Medicare Advantage plans to maximize choices for seniors, and taking action to ensure fee-for-service Medicare is not promoted over Medicare Advantage.

President's Health Reform Vision Allowance
While Americans have the best healthcare options in the world, rising healthcare costs continue to be a top financial concern for many Americans. President Trump's Health Reform Vision will protect the most vulnerable, especially those with pre-existing conditions, and provide the affordability, choice, and control Americans want and the high-quality care that all Americans deserve.

The President's Health Reform Vision would build on efforts outlined in the Executive Order, "*Improving Price and Quality Transparency in American Healthcare To Put Patients First*" to provide greater transparency of healthcare costs and enshrine the right of a patient to know the cost of care before it is delivered. It focuses on lowering the price of medicine, ending surprise medical bills, breaking down barriers to choice and competition, and reducing unnecessary regulatory burdens. The Health Reform Vision will also prioritize Federal resources for the most vulnerable and provide assistance for low-income individuals. Medicaid reform will restore balance, flexibility, integrity, and accountability to the state-federal partnership. Medicaid spending will grow at a more sustainable rate by ending the financial bias that currently favors able-bodied working-age adults over the truly vulnerable.

The Budget includes savings of $844 billion over ten years for the President's Health Reform Vision Allowance.

Paying for Outcomes
The Administration is committed to advancing a personalized and affordable healthcare system that puts the patient at the center by ensuring Federal health programs produce quality outcomes and results at the lowest possible cost.

In part, this will be achieved by our continued focus on paying for outcomes rather than procedures. For instance, the Budget seeks to improve Medicare primary care services by ensuring payments more accurately reflect clinician time, resources, and outcomes. The Budget also implements a value-based purchasing program for hospital outpatient departments,

ambulatory surgical centers, and post-acute care facilities, offering incentives to improve quality and health outcomes. Finally, the Budget proposes a set of reforms that improve the physician experience and participation in the Quality Payment Program by eliminating reporting burdens for clinicians participating in the Merit-Based Incentive Payment System, CMS's largest value-based care payment program.

The Administration issued proposed rules to modernize key regulations that advance the movement to value-based care and paying for outcomes. Specifically, the Administration proposed reforms to the Anti-Kickback Statute, the Physician Self-Referral regulations (Stark Law), and 42 CFR Part 2. These proposed rules are part of HHS's Regulatory Sprint to Coordinated Care, which aims to reduce regulatory barriers and accelerate the transformation of the healthcare system into one that better pays for value and promotes care coordination. These proposed rules reduce unnecessary regulatory burden on physicians and other healthcare providers while reinforcing their statutory intents of protecting patients from unnecessary services, and limiting fraud waste and abuse. This includes adding flexibilities with respect to outcomes-based payments and part-time arrangements. These rules would allow physicians and other healthcare providers and suppliers to design and enter into value-based arrangements that improve quality outcomes, produce health system efficiencies, and lower costs.

The CMS Center for Medicare and Medicaid Innovation (Innovation Center) launched a number of innovative payment and service delivery models to test ideas to shift our healthcare system toward payment for outcomes and health rather than sickness and procedures. This effort includes Direct Contracting and Primary Care First, a new suite of payment model options that will transform primary care to deliver better value for patients throughout the healthcare system. In addition, the Emergency Triage, Treat, and Transport Model provides greater flexibility to ambulance care teams to address emergency healthcare needs of Medicare beneficiaries following a 911 call, rather than delivering them to the hospital or emergency department for an unnecessary and expensive visit.

PROTECT LIFE AND LIVES

Combating the Opioid and Methamphetamine Crisis

In 2018, drug overdose deaths declined for the first time since 1990. A reduction in deaths from prescription opioid painkillers is almost entirely responsible for this decline. To maintain and build on this progress, HHS continues to advance the department's five-point strategy to:

- Improve access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
- Better target the availability of overdose-reversing drugs;
- Strengthen our understanding of the crisis through better public health data and reporting;
- Provide support for cutting edge research on pain and addiction; and
- Improve pain management practices.

The Budget requests $5.2 billion to address the opioid overdose epidemic and methamphetamine use, including $169 million in new resources. Funding expands State Opioid Response grants in the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide treatment, recovery support services, and relapse prevention. The Budget provides funding to

the Health Resources and Services Administration (HRSA) for Addiction Medicine Fellowships to support approximately 60 fellows annually in underserved, community-based settings that integrate primary care with mental health and substance use disorder prevention and treatment services.

While opioids have been at the forefront of the drug landscape, the crisis continues to evolve and many public health experts believe we are entering into the fourth wave of the crisis, which is underscored by increases in overdose deaths involving cocaine and methamphetamine.

HHS is leveraging current efforts to address the opioid epidemic to combat the rising mortality and morbidity associated with methamphetamines and other stimulants. To allow flexibility to most effectively combat substance use in whatever form it takes, SAMHSA's State Opioid Response grant program has the flexibility to also address stimulants. HHS would direct $50 million within NIH for research to develop medication-assisted treatment and evidence-based psychosocial treatment for methamphetamines and other stimulants.

Ending the HIV Epidemic: A Plan for America

In the 2019 State of the Union, President Trump announced a bold new initiative to reduce new HIV infections by 75 percent in the next 5 years and by 90 percent in the next 10 years, averting more than 400,000 HIV infections in that time period. This initiative focuses on four key strategies:

- Diagnose all individuals with HIV as early as possible after infection;
- Treat the infection rapidly and effectively after diagnosis, achieving sustained viral suppression;
- Protect individuals at risk for HIV using proven prevention approaches; and
- Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.

The Budget invests $716 million in dedicated funding for the second year of the *Ending the HIV Epidemic: A Plan for America* initiative, an increase of $450 million from FY 2020. This funding expands activities in the 57 target jurisdictions to increase HIV testing and access to prevention and treatment services.

With $371 million, the Centers for Disease Control and Prevention (CDC) transitions from planning to implementation and intensifies work begun in FY 2020 in the 57 target jurisdictions. CDC grants to affected communities will drive additional testing with the goal in the second year of doubling the number of new HIV diagnoses rapidly treated with antiretroviral therapy to maintain health and prevent additional HIV transmissions. Funded jurisdictions will use pharmacy data, telehealth, mobile testing, and new science-based networks to ensure individuals enter and adhere to care.

With $302 million, HRSA expands HIV prevention services to all community health centers in the targeted initiative areas and serves 28,000 additional HIV positive people through the Ryan White Program. HHS also requests $27 million for the Indian Health Service (IHS) to enhance HIV testing and linkages to care for American Indians and Alaska Natives.

NIH directs $16 million to leverage pilot data from 17 Centers for AIDS Research to design and evaluate effective, sustainable systems to implement HIV prevention and treatment interventions and rapidly implement strategies at scale that will be most effective.

These investments build on ongoing HIV activities supported across the Department and an announcement in 2019 to make pre-exposure prophylaxis medication available free of charge for up to 200,000 uninsured individuals each year for up to 11 years. The donation by Gilead Sciences, in partnership with HHS, will help reduce the risk of HIV infections, particularly for individuals that may be at the highest risk.

Improving Maternal Health

Approximately 700 women die each year in the United States from pregnancy-related complications and more than 60 percent of these deaths are preventable. In fact, women in the United States have higher rates of maternal mortality and morbidity than in any other industrialized nation – and the rates are rising. In addition to rising mortality rates, severe maternal morbidity affects more than 50,000 women and adds significant costs to the healthcare system.

Cardiovascular disease is now the leading cause of death in pregnancy and the postpartum period, constituting nearly 30 percent of pregnancy-related deaths. Chronic hypertension – which is diagnosed or present before pregnancy or before 20 weeks gestation – may result in significant maternal, fetal, and neonatal morbidity and mortality. The rate of chronic hypertension increased by 67 percent from 2000 to 2009, with the largest increase (87 percent) among African American women. CDC points to hypertensive disorders, cerebrovascular accidents, and other cardiovascular conditions as some of the leading causes of maternal deaths, all potentially preventable conditions. It is imperative to identify risk factors prior to pregnancy in order to prevent poor pregnancy and postpartum outcomes.

HHS's *Improving Maternal Health in America* initiative is addressing this significant public health problem. This initiative focuses on four strategic goals:

- Achieve healthy outcomes for all women of reproductive age by improving prevention and treatment;
- Achieve healthy pregnancies and births by prioritizing quality improvement;
- Achieve healthy futures by optimizing postpartum health; and
- Improve data and bolster research to inform future interventions.

The Budget provides a total of $116 million for this initiative across the National Institute for Research on Safety and Quality (NIRSQ), CDC, HRSA, and IHS. This includes $7 million for NIRSQ to improve service data, advance data evaluation, and expand medical expenditure surveys to ensure policy makers have timely and accurate data. The Budget also invests $24 million in CDC to expand the Maternal Mortality Review Committees to all 50 states and D.C. to ensure every case of pregnancy-related death is examined. The Budget provides $80 million in HRSA to improve the quality of maternal health services, expand access to care, and reduce disparities in care. The Budget invests $5 million in IHS to help improve health outcomes by standardizing care, increasing cultural awareness, and improving care for pregnant women.

Advancing American Kidney Health

Today's status quo in kidney care carries a tremendous financial cost. In 2016, Medicare fee-for-service spent approximately $114 billion to cover people with kidney disease, representing more than one in five dollars spent by the traditional Medicare program. In July 2019, the President signed an Executive Order launching an initiative to transform care for the estimated 37 million Americans with kidney disease. The *Advancing American Kidney Health* initiative tackles the challenges people living with kidney disease face across the stages of kidney disease, while also improving the lives of patients, their caregivers, and family members.

The Budget includes $39 million across multiple HHS agencies and requests new legislative authority in support of the initiative's three goals:

- Reduce the number of Americans developing End-Stage Renal Disease (ESRD) by 25 percent by 2030.
- Have 80 percent of new ESRD patients in 2025 receive dialysis at home or a transplant.
- Double the number of kidneys available for transplant by 2030.

This funding also supports transplantation activities for other organs.

To achieve these goals, HHS is scaling programs nationwide to optimize screening for kidney disease and educate patients on care options. HHS is also supporting innovation and groundbreaking research to inform the next generation of targeted therapies and accelerate development of innovative products such as an artificial kidney. New and pioneering payment models are also being developed to increase both value and quality of care for the patient.

The Budget also targets new funding towards HRSA's Organ Transplantation Program to remove financial disincentives for living organ donors. The Budget invests $31 million in HRSA for the Organ Transplantation program, including $18.3 million for the Organ Procurement Transplantation Network, Scientific Registry of Transplant Recipients, and public and professional education efforts to increase public awareness about the need for organ donation. In addition, the proposed rule to increase accountability and availability of the organ supply – announced in December 2019 – would improve the donation and transplantation rate measures, incentivize Organ Procurement Organizations (OPOs) to ensure all viable organs are transplanted, and hold OPOs to greater oversight, transparency, and accountability while driving higher OPO performance.

HHS is working to accelerate innovation in the prevention, diagnosis, and treatment of kidney disease through the Kidney Innovation Accelerator (KidneyX), a public-private partnership between HHS and the American Society of Nephrology. The HHS Office of the Chief Technology Officer will continue the KidneyX competition in FY 2021 by challenging individuals, teams, and companies to build and test prototype solutions, or components of solutions, that can replicate normal kidney functions or improve dialysis access.

The Budget proposes to establish a new program within the Office of the Assistant Secretary for Preparedness and Response (ASPR) that will advance kidney health. The Preparedness and Response Innovation program will support advanced research and development, prototyping and

procurement of revolutionary health security products, technologies and other innovations. The program's first project will focus on portable dialysis equipment for emergency response. This will ensure that individuals with kidney failure have access to dialysis during a disaster.

The Budget also advances legislative proposals to revolutionize the way patients with chronic kidney disease and kidney failure are diagnosed, treated, and supported. This effort includes extensions of both the NIH Special Diabetes Program and IHS Special Diabetes Program for Indians to address chronic conditions, such as diabetes, that can lead to kidney disease.

For patients who lose Medicare coverage at 36 months post-transplant and who do not have another source of healthcare coverage, the costs of continuing immunosuppressive drug therapy may be prohibitive. Without these drugs, the patient's body rejects the transplant, reverts to kidney failure, and requires dialysis. To prevent transplant rejection and reversion to dialysis, the Budget proposes to establish a new federal program that provides lifetime coverage of immunosuppressive drugs for certain kidney transplant recipients until they are otherwise eligible for Medicare coverage. The Budget also proposes to increase competition among, and oversight over, Organ Procurement Organizations to improve performance and increase the supply of organs for transplant. In addition, the Budget advances new innovative kidney care payment models to encourage home dialysis, increase access to kidney transplants, and incentivize clinicians to better manage care for patients with kidney disease.

Transforming Rural Health

There are 57 million Americans living in rural communities. Rural Americans face many unique health challenges, including hospitals that are closing or in danger of closing; difficulty recruiting and retaining physicians, nurses, and other providers; and increased likelihood of dying from many leading causes of avoidable death such as cancer and heart disease.

HHS's *4-Point Strategy to Transform Rural Health* builds on current HHS initiatives in the following areas:

- Build a Sustainable Health Model for Rural Communities;
- Leverage Technology and Innovation;
- Focus on Preventing Disease and Mortality; and
- Increase Rural Access to Healthcare.

The Budget supports rural communities through programs such as the Rural Communities Opioids Response Program and the Telehealth Network Grant Program at HRSA, which supports substance use prevention, treatment, and recovery services, and promotes telehealth technologies for healthcare delivery in rural communities. Project AWARE (Advancing Wellness and Resiliency in Education) will increase mental health awareness training in rural communities. In response to American Indian and Alaska Native communities' demand for telebehavioral services, IHS expands the Telebehavioral Health Center of Excellence with funding for new space, updated equipment, and additional behavioral health providers.

Telehealth services strive to make rural health programs more effective, increase the quality of healthcare, and improve health outcomes. The Budget seeks to remove barriers to telehealth services in rural and underserved areas through a proposal to expand telehealth services in

Medicare fee-for-service advanced payments models with more than nominal financial risk. This proposal broadens beneficiary access to Medicare telehealth services and addresses longstanding stakeholder concerns that the current statutory restrictions hinder beneficiary access. The proposal expands the telehealth benefit in Medicare Fee-for-Service and provides authority for Rural Health Clinics and Federally Qualified Health Centers to be distant site providers for Medicare telehealth services. It also permits IHS and tribal facilities to be originating and distant site providers, even if the facility does not meet the requirements for being located in certain rural or shortage areas, and allows for coverage across state lines. The Budget also proposes to modernize payments to Rural Health Clinics to ensure equitable payment for these health clinics and help rural communities maintain access to these crucial services. Finally, the Budget proposes to allow Critical Access Hospitals to voluntarily convert to an emergency hospital that does not maintain inpatient beds.

Addressing Tick-borne Diseases

Tick-borne diseases, of which Lyme Disease is the most common, account for 80 percent of all reported vector-borne disease cases each year and represent an important emerging public health threat in the United States. With 59,349 reported cases in 2017, the annual number of reported cases has more than tripled over the last 20 years; due to under-reporting, this number substantially under-represents actual disease occurrence. The geographic ranges of ticks are also expanding, which leads to increased risk for human exposure to the bites of infected ticks. Most humans are infected through bites from very small young ticks, hosted by deer or mice.

To address critical gaps in knowledge, diagnostics, and preventive measures for tick-borne diseases, HHS is proposing an action plan that will prioritize and advance the most promising candidates and technologies for diagnosing and preventing Lyme and other tick-borne diseases. This plan, led by the Office of the Assistant Secretary for Health in partnership with NIH, CDC, and FDA, will address four primary areas: innovations in diagnosis and advanced detection, developing vaccine-based prevention, ensuring robust domestic surveillance of vector borne diseases, and providing additional knowledge to advance the best treatment and prevention options. These efforts will improve outcomes for those affected by Lyme Disease symptoms. This plan builds on the Kay Hagan Tick Act, enacted through the Consolidated Appropriations Act for 2020, to improve research, prevention, diagnostics, and treatment for tick-borne diseases.

The Budget requests $189 million, an increase of $58 million, to address tick-borne diseases. This amount includes $115 million for NIH to expand its research on of tick-borne disease, including in the prevention, diagnosis, and treatment; and $66 million for CDC to address vector-borne diseases, focusing on tick-borne diseases, including tick surveillance, insecticide resistance activities, and development of improved diagnostics. FDA will ensure the safety and efficacy of products developed to prevent, diagnose, and treat vector-borne diseases.

Focusing on Influenza

Influenza is a serious disease that can lead to hospitalization and sometimes death, even among healthy people. In the United States, millions of people are sickened, hundreds of thousands are hospitalized, and tens of thousands die from influenza every year. In September 2019, the President signed Executive Order 13887, *Modernizing Influenza Vaccines in the United States to*

Promote National Security and Public Health. The Executive Order recognized influenza as a public health threat and national security priority, and directed HHS to prepare and protect the nation.

The Budget invests $998 million to continue on-going influenza activities as well as targeted increases to support this directive. This amount includes $306 million for ASPR to modernize influenza vaccine manufacturing infrastructure and advance medical countermeasure research and development. Activities include additional clinical studies on licensure of pre-pandemic recombinant-based influenza vaccine and the advanced development of novel diagnostics, respiratory protective devices, and alternative vaccine delivery technology. The Budget also funds the Office of Global Affairs to support US leadership of international efforts on pandemic influenza preparedness.

The Budget requests $216 million for CDC's Influenza program, an increase of $40 million. CDC will expand influenza vaccine effectiveness monitoring systems and develop and characterize candidate vaccine viruses for vaccine manufacturers, and efforts to improve the evidence-base on non-egg-based vaccines. CDC will support whole genome characterization of more than 10,000 influenza viruses. All of these activities help build domestic capacity. CDC will also increase influenza vaccine use by removing barriers to vaccination and enhance communication to healthcare providers about the performance of influenza vaccines.

The Executive Order also calls for the development of novel technologies to speed seed vaccine development, targeted development of vaccines that protect against multiple types of virus for multiple years, and to improve adjuvants. In support of this goal, the Budget includes $49 million for FDA to support regulatory science research and clinical assessments to promote development and access to safe and effective influenza vaccines, and $423 million for NIH to accelerate influenza research, including universal flu vaccine development.

Emergency Preparedness

HHS plays a key role in supporting domestic and international preparedness and response to ensure our nation's safety. The Budget invests $2.6 billion in ASPR to expand efforts to prevent, prepare for, respond to, and recover from, the adverse health effects of public health emergencies. This amount includes $562 million for the Biomedical Advanced Research and Development Authority to maintain a robust pipeline of innovative medical countermeasures that mitigate health effects of infectious diseases and chemical, biological, radiological, and nuclear agents. It also includes $535 million for Project BioShield to support procurement of medical countermeasures against these threats, and $705 million for the Strategic National Stockpile to sustain and increase inventory of high-priority countermeasures such as antibiotics to treat anthrax exposure and vaccine to prevent smallpox. These investments will help HHS advance progress towards national preparedness goals.

NIH supports a robust research portfolio to develop vaccines and therapeutics that enable rapid response to public health threats including emerging microbial threats, such as extensively drug-resistant tuberculosis, emerging viral strains such as Zika, and viral hemorrhagic fevers such as Ebola. The Budget continues investments in NIH in scientific research on these new threats, and

invests $120 million in FDA to facilitate medical countermeasure development and availability to respond in the event of a microbial or other public health threat.

Strengthening the Indian Health Service
The Administration is committed to improving the health and well-being of American Indians and Alaska Natives. This population continues to experience significant health disparities, and the Budget includes key investments to ensure quality of care. The Budget invests $6.2 billion in IHS, which includes $125 million for electronic health record modernization, provides funding to support IHS Services, Ending the HIV Epidemic, and Maternal Health, and includes $125 million for high-priority healthcare facilities construction projects. The Budget proposes a new, indefinite discretionary appropriation and reforms for IHS to address Indian Self-Determination and Education Assistance Act section 105(*l*) lease costs.

Reforming Oversight of Tobacco Products
The Budget proposes to move the Center for Tobacco Products out of FDA and create a new agency within HHS to focus on tobacco regulation. A new agency with a mission focused on tobacco and its impact on public health would have greater capacity to respond rapidly to the growing complexity of new tobacco products. Additionally, this reorganization will allow the FDA Commissioner to focus on its traditional mission of ensuring the safety of our nation's drug, food, and medical products supply.

Providing Shelter and Services for Unaccompanied Alien Children
The Administration for Children and Families (ACF) provides shelter, care, and support for unaccompanied alien children apprehended by the Department of Homeland Security or other Federal Government department or agency. The number of unaccompanied alien children requiring care is inherently unpredictable. In FY 2019, ACF cared for 69,488 children, the highest number in the program's history. To ensure adequate shelter capacity and care in FY 2021, the Budget requests a total of $2 billion in discretionary funds to support capacity of 16,000 licensed permanent beds, depending on operational needs, and includes a mandatory contingency fund to provide up to $2 billion in additional resources if needed.

PROMOTE INDEPENDENCE

Promoting Upward Mobility
In the human services work at HHS, the overarching goal is to promote personal responsibility, independence, and self-sufficiency—to help Americans lead flourishing, fulfilling, independent lives. HHS programs for low-income Americans achieve this goal by supporting work, marriage, and family life. HHS seeks to better align our social safety net programs with the booming economy, and focus on work as the means to lift families out of poverty.

Many Americans are joining the workforce as the Administration's policies continue to strengthen the economy and produce historically low unemployment rates. The Administration supports working families by investing in child care, an important work support that helps families achieve independence and self-sufficiency. The Administration is working to implement policies that increase access to high-quality, affordable child care.

The Budget proposes to improve the Temporary Assistance for Needy Families (TANF) program by restoring its focus on employment and work preparation, and by targeting funds to low-income families. The proposal fundamentally changes the way the program measures success by moving to measures that focus on employment outcomes, phasing out the ineffective work participation rate. In addition, the Budget establishes Opportunity and Economic Mobility Demonstrations that allow for the streamlining of funding from multiple safety net programs to deliver coordinated and effective services. The Budget also seeks to improve consistency between work requirements in TANF and Medicaid by requiring that able-bodied individuals participate in work activities at least 20 hours per week in order to receive welfare benefits.

Supporting Child Care

Child care is an investment in both present and future generations of the workforce. However, it is also one of the biggest expenses for families and can be a barrier to work. Funding plays a critical role in helping families achieve self-sufficiency by providing parents access to a range of child care options. In FY 2018, the most recent year for which preliminary data are available, over 1.3 million children from about 813,000 low-income families received a monthly child care subsidy from the Child Care and Development Fund. The Budget provides $5.8 billion for the Child Care and Development Block Grant and $4.2 billion in mandatory child care funding for a total investment of $10.0 billion in child care. The mandatory funding includes a one-time $1 billion fund for competitive grants to states to increase child care services for underserved populations and stimulate employer investment in child care. The Budget will serve 1.9 million children.

Promoting Adoption

Adoption gives children stability and love during their childhood, and also a safe and stable environment in which to grow into responsible adults who flourish. Approximately 20,000 youth exit or "age out" of foster care each year without the safety net of a forever family, and their outcomes are often concerning. A longitudinal study found that only 58 percent graduated from high school, and only half found employment by age 24. More than a third of youth in one study had experienced homelessness at least once by age 26. Children and young adults in foster care cannot be expected to achieve the independence they need to thrive and flourish on their own—but finding them a loving forever family could change all that.

According to ACF, the number of children adopted with help from public child welfare agencies rose from 59,000 in FY 2017 to more than 63,000 in FY 2018. To sustain this momentum, ACF has launched a Call to Action for states and other stakeholders, which aims to develop and sustain key partnerships across public and private groups, including faith-based groups, with the goal of reducing the number of children in foster care and increasing the number of children who find a forever family, through adoption or otherwise.

The Adoption Assistance and Guardianship Assistance programs will provide $4.1 billion in FY 2021 in mandatory funding to provide monthly support payments to families adopting sibling

groups or other children with special needs. Under existing law, Adoption Assistance funding will keep pace with the number of qualifying children adopted each year.

HHS promotes adoption through administrative actions and funding incentives to promote adoption, and to identify and address barriers to adoption. Initiatives include family-finding programs, focusing on identifying the barriers that exist in the recruitment and development of foster and adoptive families, and the development and dissemination of court-related practice improvements addressing barriers to timely adoptions.

Supporting Families and Preventing the Need for Foster Care

Helping families receive the care and services they need before the involvement of a child welfare agency can help prevent a child from entering foster care. The Administration has focused on primary prevention, as well as adoption, and we are starting to see better results. HHS is implementing the Family First Prevention Services Act (Family First Act), which supports services to prevent child maltreatment and the need for foster care. This groundbreaking new legislation provides the opportunity for substantial improvements in outcomes for children and families. The Budget proposes to streamline the process for evaluating evidence-based prevention services programs under the Family First Act to give states and tribes access to more programs that help prevent the need for foster care and assist kinship caregivers.

The Budget invests $510 million for discretionary child welfare activities in ACF, including services that allow children to remain safely with their families and education and training vouchers for youth aging out of foster care. In collaboration with CMS, the Budget proposes that Qualified Residential Treatment Programs (QRTPs) be exempted from the institution for mental diseases (IMD) payment exclusion allowing children in foster care to have Medicaid coverage in these placements even if a QRTP qualifies as an IMD.

The Budget provides $197 million to ACF for child abuse prevention grants. These grants support increased use of evidence-based prevention programs, allowing states to explore new research opportunities and to adapt more rigorous evaluations of existing programs; demonstration projects to test the effectiveness of partnerships that strengthen family capacity and prevent child abuse through the co-location of services; and state plans for safe care of infants affected by substance use disorders.

The Budget also proposes to expand the Regional Partnership Grant program by $40 million each year, which will increase funding for grants that help courts, child welfare agencies, and other government and community entities work together and improve practices to address the impact of substance abuse, including opioids, on child welfare. The Budget proposes an increase of $30 million each year for the Court Improvement Program to help courts improve practices and comply with new mandates in the Family First Act.

Strengthening Efforts to Treat Serious Mental Illness and Serious Emotional Disturbances
In 2018, more than 11 million adults in the U.S. were living with a serious mental illness. More than 7 million children and youth experienced a serious emotional disturbance. They faced a greater risk of suicide and life expectancy 10 years shorter than the general population.

The Budget provides $1.1 billion to SAMHSA for serious mental illness and serious emotional disturbances, which includes funding to support Assertive Community Treatment for Individuals with Serious Mental Illness, Community Mental Health Services Block Grant, and Children's Mental Health Services. These programs provide comprehensive and coordinated mental health services for some of the nation's most vulnerable populations and increases access to mental health services in schools. The Budget will also provide targeted flexibility for states to provide inpatient mental health services to Medicaid beneficiaries with serious mental illness.

The Budget also invests in programs that address the nation's alarming rates of suicide. Suicide is the 10th leading cause of death in the United States – responsible for more than 47,000 deaths in 2017 – and suicide rates have increased steadily for individuals of all ages. The Budget provides $93 million for suicide prevention activities, including additional funding to expand Zero Suicide initiatives to focus on adult suicide prevention and allow communities and states to tailor strategies to prevent suicide in their local jurisdictions.

Supporting Independence for Older Adults and People with Disabilities
The Administration prioritizes community living for older adults and people with disabilities to ensure that they can maintain independence and live fully integrated in their communities. The Budget invests $1.5 billion in the Administration for Community Living for critical direct services that enable seniors and people with disabilities to live independently, such as senior meals, in-home chore assistance, independent living skills training, employment training, and information and referral services. These programs empower older adults and people with disabilities to live independently and make critical choices about their own lives.

PROMOTE EFFECTIVE AND EFFICIENT MANAGEMENT AND STEWARDSHIP

HHS is responsible for more than one-quarter of total federal outlays. The Department administers more grant dollars than all other federal agencies combined. HHS is committed to responsible stewardship of taxpayer dollars, and the Budget continues to support key reforms that improve the efficiency of Departmental operations.

Advancing Fiscal Stewardship
The Administration recognizes its immense responsibility to manage taxpayer dollars wisely. HHS ensures the integrity of all its financial transactions by leveraging financial management expertise, implementing strong business processes, and effectively managing risk.

As the Department overseeing Medicare and Medicaid, HHS is committed to exercising proper oversight of these programs to protect the millions of impacted beneficiaries and the taxpayers in general. In accordance with the direction in the Executive Order on *Improving and Protecting*

Medicare, HHS is investing in the newest technological advancements, such as Artificial Intelligence, to enhance our ability to detect and prevent fraud, waste, and abuse.

The Department is committed to reducing improper payments in Medicare, Medicaid, and Children's Health Insurance Program (CHIP). HHS continues to enhance existing program integrity tools to address improper payments and prevent fraud, including provider screening, prior authorization, and auditing providers and plans. New methods and technologies will allow HHS oversight to reduce improper payments and adapt to the changes in healthcare as we shift from a fee-for-service to a value-based healthcare payment system.

The Budget advances new legislative and administrative proposals to strengthen the Department's ability to address weaknesses in Medicaid beneficiary eligibility determination processes, while providing tools to facilitate the recovery of overpayments made by states. HHS also continues to support updates to Medicaid information systems that offer critical support to program integrity efforts, including the Transformed Medicaid Statistical Information System (T-MSIS) and a new Medicaid drug rebate system. In addition, HHS includes proposals that enhance oversight of Medicare Advantage and Part D plans, increase the period of enhanced oversight on new providers, and expand Medicare fee-for-service prior authorization.

Implementing ReImagine HHS

HHS supports the President's Management Agenda through *ReImagine HHS*, the Department's robust reform and transformation effort, organized around core goals to streamline processes, reduce burden, and realize cost savings. The effort takes an enterprise approach, affecting activities across the Department. For example, the Buy Smarter initiative plans to use new and emerging technologies to leverage the enormous purchasing power of HHS and streamline the end-to-end procurement process. The Maximize Talent initiative addresses modern-day human capital management and human resources operational challenges, resulting in key achievements: HHS's simplified recruitment process resulted in a significant increase in the number of new hires on-boarded since implementation, and HHS was rated the "Best Place to Work in the Federal Government" out of all executive departments in 2019. As part of the Bring Common Sense to Food Regulation initiative, FDA is working to increase collaboration between food regulatory programs to minimize dual jurisdiction and improve state product safety. As a result, 48 states and territories participate in the Produce Safety Implementation Cooperative Agreement Program, which increased state large farm inspections over 400 percent in FY 2019.

ReImagine HHS efforts are also making HHS more innovative and responsive. Under the Optimizing Regional Performance initiative, HHS developed a Regional Facilities Utilization Model with $150 million in potential savings and a footprint reduction of more than 62 percent within ten years. For the first time since 1974, HHS completed a comprehensive assessment of regions to better align with Administration priorities and improve HHS's ability to serve Americans across the country. In addition, under the Optimize Coordination Across HHS initiative, HHS configured a new cloud environment for an administrative data hub to provide dashboarding capabilities for Operating Divisions, bringing together human resources, travel, and facilities data to inform better decision-making across the enterprise.

In FY 2021, all *ReImagine HHS* projects will reside in their permanent offices within HHS. This ensures that their work can sustainably continue going forward.

Grants Management

HHS continues to drive change for grants management government-wide. Leveraging the efforts and success of the HHS ReImagine Grants Management initiative. The Office of Management and Budget pre-designated HHS as the Grants Quality Services Management Office (QSMO) to create and manage a marketplace of solutions for grants management; govern its long-term sustainability; institute a customer engagement model; and drive the implementation of standards and solutions to modernize grants management processes and systems. Guided by a government-wide governance board, QSMOs are tasked with offering solutions that, over time, will improve quality of service and customer satisfaction; modernize and automate processes and supporting technology; standardize processes and data; and achieve efficiencies in government-wide operations and maintenance.

In FY 2018, the government awarded over $750 billion in grants to approximately 40,000 recipients across more than 1,500 programs.

Full designation as the Grants QSMO is contingent upon approval of a 5-Year Implementation Plan and budget estimate in alignment with the published QSMO Long-term Designation Criteria. HHS is developing a vision and strategy to inform the Grants QSMO 5-Year Implementation Plan, with significant engagement with stakeholders to ensure the Grants QSMO can meet their diverse needs.

Regulatory Reduction

HHS is committed to streamlining the regulatory process and evaluating necessary steps to eliminate or change regulations that impose unnecessary burden. Burdensome regulations can drive up costs of healthcare, while poorly designed regulations can come between doctors and patients, reducing the quality of care and the essential trust to that relationship. From FY 2017 to FY 2019, HHS succeeded in cutting the economic burden of its regulations by $25.7 billion through 46 deregulatory actions. HHS had the largest deregulatory impact of any Cabinet agency during this time period.

HHS is using the power of new cognitive technologies for greater operational effectiveness and research insights, including regulatory reduction. HHS used an Artificial Intelligence-driven regulation analysis tool and expert insight to analyze the Code of Federal Regulations, seeking potential opportunities to modernize regulations. HHS since launched a Department-wide Regulatory Clean-Up Initiative to implement changes based on these findings, by reviewing and – where a change is warranted – addressing incorrect citations and eliminating the submission of triplicate or quadruplicate of the same citation.

HHS is working to implement the provisions of the Executive Order on *Promoting the Rule of Law through Improved Agency Guidance Documents*. This Executive Order will accomplish important policy goals that will improve HHS guidance practices in the long term. Prior to the issuance of this Executive Order, several Federal agencies issued internal memoranda regarding the appropriate use of guidance. The Executive Order requires agencies to now go a step further

and codify certain good guidance practices and policies into Federal regulations. By August 27, 2020, each agency must finalize regulations to set forth processes and procedures for issuing guidance documents. In addition, by February 28, 2020, Federal agencies must establish a single, searchable database on its website that contains, or links to, all of the agency's guidance documents currently in effect. Any guidance document not included in the guidance website is deemed rescinded. HHS is committed to meeting the President's timelines.

Chairman YARMUTH. I thank you for your remarks. And, as a reminder, again, Members can submit written questions to be answered later in writing.

And, as Deputy Secretary Hargan and I discussed yesterday, there may be areas which you don't specifically have the expertise in, but you are happy to get answers from the Department.

Mr. HARGAN. Absolutely.

Chairman YARMUTH. So I want all the Members to know that.

And those questions and the answers from the Department will be made part of the formal hearing record. Any Members who wish to submit questions for the record may do so within seven days.

As we usually do, the Ranking Member and I will defer our questions until the end. And because the coronavirus spread significantly in Washington state, and reports of nine deaths due to the virus there, this has directly affected Ms. Jayapal's district. For that reason, as a matter of courtesy, I now recognize the gentlewoman from Washington state, Ms. Jayapal, for five minutes.

Ms. JAYAPAL. Thank you, Mr. Chairman, and thank you, Deputy Secretary, for being with us.

As you know, my home state of Washington was the first to experience a coronavirus case back in January. We are now looking at nine deaths in the state of Washington. I am incredibly proud of our state's first responders, public health officials, and infrastructure that has been built, and the tremendous efforts and work that they have put forward.

I do have to tell you that the response efforts have resulted in an estimated $200,000 a week of unexpected costs in Seattle and King County alone. People on the front lines, including health workers and emergency service personnel, were not provided with adequate personal protective equipment in advance. And the initial botched test kits and the slow response from the Administration on testing protocols were incredibly detrimental to our efforts.

In fact, Washington State is still waiting for half of the requested medical supplies for response efforts. Calling this a hoax, as President Trump did in the early days of this virus, was extremely damaging. And taking just $2.5 billion dollars from other needed sources, as the Administration's initial response to this, was simply not sufficient.

Thanks to appropriators, we will, hopefully, have an $8 billion-plus package that we will pass through the House.

But it is time, Mr. Deputy Secretary, to stop playing politics with this. We are losing people's lives as a result.

I want to start by asking you, is it a public health priority to ensure that anybody who is experiencing these symptoms and/or has been in contact with an infected person comes to get a test?

Mr. HARGAN. Well, thank you for that, Congresswoman. And I just want to say my sincerest condolences go out to all the families who have lost loved ones in Washington, and our sympathies to them. Any loss of life is a tragedy. And of the nine individuals that have passed, we know five were residents of a nursing home there in Washington. And also our thoughts go out to the health care workers in Washington, as you pointed out, the first responders and everyone who has been dealing——

Ms. JAYAPAL. Thank you. They need the supplies, they need the tests, they need the protective equipment. But thank you for that.

Mr. HARGAN. Yes, exactly.

Ms. JAYAPAL. And if you could just——

Mr. HARGAN. And as for the tests, I think that, for anything with regard to particularities, I want to make sure everyone goes to CDC.gov for the recommendations that the federal government——

Ms. JAYAPAL. Can I just ask you to answer the question, Deputy Secretary?

Mr. HARGAN. Sure.

Ms. JAYAPAL. Is it necessary, in order to prevent a public health crisis here in this country, that we ensure that everybody who has experienced the symptoms, or believes to be in touch with an infected person, goes in to seek testing?

Mr. HARGAN. I believe that——

Ms. JAYAPAL. Or public health support.

Mr. HARGAN. Right——

Ms. JAYAPAL. Is that necessary?

Mr. HARGAN. I believe that, you know, given the symptoms of the disease—and I will defer to clinicians on exactly what is done with testing. However, to repeat what our public health professionals have said, everyone—the symptoms of this disease resemble other respiratory illnesses. In many cases, people get the disease and do not know——

Ms. JAYAPAL. Is it a priority for people to seek care?

Mr. HARGAN. People should—if people seek care—many times with mild and moderate illnesses, people are recommended to stay home, to treat themselves. People who need medical care should come to a health care facility. And——

Ms. JAYAPAL. So it is a priority for people——

Mr. HARGAN. And——

Ms. JAYAPAL [continuing]. who experience the symptoms that are described by CDC's protocol to come in and seek care. Is that correct?

Mr. HARGAN. For the level of severity that they announce. So it is——

Ms. JAYAPAL. Thank you.

Mr. HARGAN. So, in other words, CDC does not say everyone who is experiencing any level of some kind of—that seems like——

Ms. JAYAPAL. No, they have laid out a very clear protocol——

Mr. HARGAN. Right.

Ms. JAYAPAL [continuing]. and set of guidelines.

Mr. HARGAN. Yes.

Ms. JAYAPAL. For those people that experienced that——

Mr. HARGAN. For those people——

Ms. JAYAPAL [continuing]. that have been in touch with infected people, is it a priority to come in and seek care?

Mr. HARGAN. They should follow CDC's protocols, and local and state health authorities should consult those, and look at their plans——

Ms. JAYAPAL. OK.

Mr. HARGAN [continuing]. to make recommendations——

Ms. JAYAPAL. What about the Administration's public charge rule that has created a chilling effect for people to come in and seek care?

Are you telling the Department of Homeland Security and the Administration that that is not helping to contain what may be an impending pandemic that would affect every American, not just those Americans who don't seek that care?

Mr. HARGAN. I would have to defer questions on that rule to the Department of Homeland Security.

Ms. JAYAPAL. But don't you think that is important, as a public health official, the Deputy Secretary of the Department of Public Health, to ensure that people do not face those barriers if they are experiencing those protocols?

Mr. HARGAN. Any local decision about how someone responds and gets care is, you know—obviously, that is a matter of public health import. However, any questions about the particular rule should go to Homeland Security. They are——

Ms. JAYAPAL. I would hope that you——

Mr. HARGAN. That is their rule.

Ms. JAYAPAL [continuing]. would let the Department of Homeland Security know that this is a public health issue for all Americans, that people do not seek care because they are afraid that they are going to be deported the next day, or seen as a public charge.

Mr. Deputy Secretary, some individuals have gotten tested, found that they are tested negative, and now they owe over thousands of dollars in medical bills. In a health care system in which 70 million people are uninsured or under-insured, and which over 500,000 people are declaring bankruptcy every day—every year due to medical bills, what is your plan to work with insurance companies, pharmaceutical companies, and hospitals to make sure that people don't go home with bills that may bankrupt them?

Mr. HARGAN. You know, we do maintain support for the ACA exchanges that provide insurance on the exchanges. We have many options and choices that are available in this country for people to finance their care.

We also provide increased support to community health centers. We are very supportive of them. They provide care for many millions of Americans at reduced cost, and they are available in communities around this country.

Ms. JAYAPAL. You are aware that, as the Ranking Member has undermined the Medicare for All bill, which would provide universal health care for everybody, the Trump Administration has worked very hard to cut the care that is provided under the Affordable Care Act. I hope you are aware of that. It has serious implications now, during this time of crisis for many people across my state and, frankly, across the country.

Mr. Chairman, I know my time has yielded.

Chairman YARMUTH. That is all right.

Ms. JAYAPAL. I thank you for your generosity.

Chairman YARMUTH. The gentlewoman's time has expired. I now recognize the gentleman from Ohio, Mr. Johnson, for five minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. I am really actually glad to hear my colleague acknowledge the skyrocketing cost of

health care, the lack of access, the number of under-insured. Thank you, Obamacare. I am glad you acknowledged that.

Mr. Chairman, thanks for today's hearing.

And Mr. Hargan, thank you for coming in to address our Committee today. I am glad we are here to discuss the President's Fiscal Year 2021 Department of Health and Human Services budget request.

I am frustrated that this Committee has once again convened a hearing to discuss the President's budget when my Democrat colleagues refuse to produce a budget proposal of their own. It is easy to sit up here and criticize the work that has already been done, but it is the job of this Committee to produce a budget, address our nation's fiscal challenges, and ensure that our government's finite resources are helping to grow the economy, create jobs, and raise wages for all.

Last month this Committee held a hearing on the President's 2021 budget request, and I heard a lot of criticism from my Democrat colleagues about how the President's budget takes a wrecking ball to America's economic future and security. In fact, a senior Democrat on this Committee said that the President's destructive and irrational budget intentionally goes after working families and vulnerable Americans.

I can tell you, as the representative of rural eastern and southeastern Ohio, I could not disagree more. I applaud the Trump Administration's proposed investments in rural America, including much-needed and overdue investments in rural broadband and telehealth services. We have seen the unemployment rate in my district decline by upwards of 60 percent across the spectrum of the 18 counties that I represent. It is working, and it is working for rural America.

Telehealth is a powerful tool for improving access to healthcare for all Americans, but especially rural Americans like those that I represent. As the co-Chair of the Congressional Telehealth Caucus, I have had the opportunity to witness telehealth in action in my district. Whether it is robots that help seniors receive care in the comfort of their own home, or a video conferencing tool that enables stroke specialists, neurosurgeons to consult with geographically separated doctors to give the best care possible, the opportunities are limitless and they are lifesaving. And I believe we have only scratched the surface of what it can do.

So, Mr. Hargan, can you tell me what HHS is currently doing to promote and expand access to telehealth services?

Mr. HARGAN. You are absolutely right. Thank you, Congressman, for that. Coming from a rural—from rural Illinois, I understand very well what you are talking about there.

Telehealth is an important aspect that we have to make sure that we expand access to it, particularly for rural and remote areas where there isn't otherwise able—where people aren't otherwise able to get access.

Some of the things that we have done so far is that Medicare now provides—pays providers for new communication technology-based services, like brief check-ins between patients and practitioners, and also evaluation of remote, pre-recorded images and video. So, now that we pay for that, the providers are going to be

incentivized to actually participate in that. So that provides an incentive for them.

We are also working with advanced payment models to be able to remove barriers to telehealth services within Medicare to make sure that rural and under-served areas are getting expanded telehealth services where there is more than nominal financial risk.

We also are allowing rural health clinics and federally qualified health centers, which, in many cases, including in my own community, are where providers—where we actually have services provided to be distant site providers for Medicare telehealth, and makes the services as eligible payments under the Medicare physician fee schedule.

So we have done all of those things. We are taking regulatory actions to be able to free up the use of telehealth in rural and remote settings.

Mr. JOHNSON. OK. All right. Quickly, you know, I believe telehealth could be a critical tool to help fight off the coronavirus and respond to that virus. I am working with my colleagues on both sides of the aisle to get a provision that is in the Connect Back—Connect for Health Act in the emergency coronavirus supplemental package to give the HHS Secretary the authority to waive telehealth restrictions during national emergencies, which could help prevent a run on the health care system in—especially in rural America.

So, Mr. Hargan, do you believe that waiving telehealth restrictions during national emergencies would benefit how HHS and the Administration combat the outbreak of coronavirus?

Mr. HARGAN. I believe that could be—like, providing greater access to telehealth in situations can be a tremendous help, especially because it helps relieve congestion on what could be overburdened local health care systems, and allows patients to be at home, isolated in certain circumstances, and still have access to professional care. So it is—I think it is very important.

We would love to work with you all to provide technical assistance, whatever else you need, to be able to work through issues like that in a——

Mr. JOHNSON. Well, we are working to get it in the supplemental. I hope my colleagues on the other side of the aisle will join us in trying to get that done.

Thank you, Mr. Chairman. I yield back.

Chairman YARMUTH. It sounds like a good idea I will say to my colleague from Ohio.

Mr. JOHNSON. Thank you, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the Vice Chairman of the Committee, the gentleman from Massachusetts, Mr. Moulton, for five minutes.

Mr. MOULTON. I thank you. You know, Mr. Chairman, it is remarkable that my colleague across the other aisle, after five concerted minutes of a real decent back-and-forth between the deputy secretary and the representative of a district who has lost men and women, good Americans to coronavirus, that he had to start with a partisan attack on Medicare for All.

You know, I don't personally support Medicare for All, but I certainly support the principle that we should be expanding health care access to Americans.

And you know what? Health care budgets are going up because our population is growing, and we want to have more Americans get good health care.

Mr. JOHNSON. Would the gentleman yield?

Mr. MOULTON. The deputy—no.

Deputy Secretary, I appreciate your seriousness with which you are approaching both the coronavirus and your broader duties, because, look, there has been a lot of partisan talking points thrown about. I understand that the Trump Administration is no more responsible for the coronavirus than Corona is. But the Trump Administration, and your institution in particular, is responsible for preparing for diseases and pandemics, for responding to them, and for keeping Americans healthy. So I have a number of questions.

Deputy Secretary Hargan, would you or your boss like to revise your Fiscal Year 2021 budget request for the Infectious Disease Rapid Response Reserve Fund, or the National Institute of Allergy Infectious Disease—or Infectious Diseases?

Mr. HARGAN. I think that, whatever we are—obviously, the President has indicated willingness to work with revisions to the supplemental request, and I think we are going to engage on all fronts in deciding exactly how the money should be apportioned. And——

Mr. MOULTON. Well, I hope that is a yes, because your budget cuts CDC's Infectious Disease Rapid Response Fund by $35 million, a pattern that dates back to a request of exactly zero dollars for Fiscal Year 2019.

Would under-funding an account in Fiscal Year 2021 that has already been tapped this year for coronavirus help our response?

Mr. HARGAN. I think we have asked for $135 million more for CDC's——

Mr. MOULTON. Well, I assume no, because——

Mr. HARGAN [continuing]. Infectious Disease Response——

Mr. MOULTON [continuing]. because you have—I am—you have asked for more, which I appreciate.

Your budget request also reduces NIH's National Institute of Allergy and Infectious Diseases funding to levels below that which was appropriated in fiscal 2019 and Fiscal Year 2020. Will this improve our ability to conduct and support research on the coronavirus or other outbreaks?

Mr. HARGAN. I think that we will engage on the supplemental to decide exactly what portion——

Mr. MOULTON. But would your—will your cut improve our response?

Mr. HARGAN [continuing]. CDC. Well, I think we have advocated for at least $2.5 billion more dedicated to the corona response in the supplemental request——

Mr. MOULTON. Well, I am glad to hear that, frankly, you have the courage to disagree with the President's budget request. I appreciate that, because it shows that you and the professionals at HHS are doing their job.

When President Trump announced that Vice President Pence would be his coronavirus czar, he declared that the risk of coronavirus to the American public, "remains very low." Vice President Pence echoed this concern.

Now, the World Health Organization, on the other hand, has warned that coronavirus could be classified as a global pandemic in the near future, if not today. Is WHO wrong when it signals potentially elevating the classification of COVID–19?

Mr. HARGAN. WHO has its own responsibilities in its nomenclature, and it is responsible for declaring whether something is, under their view, a pandemic or not.

Mr. MOULTON. So do you think they are right or wrong?

Mr. HARGAN. We will do exactly what the response is that we need for the American people, regardless of what the WHO says——

Mr. MOULTON. I understand that.

Mr. HARGAN [continuing]. or how they declare it or——

Mr. MOULTON. I understand that. Do you think that they are right or wrong?

Mr. HARGAN. I don't intend to oversee their operations of the World Health Organization. Whatever they decide in terms of their nomenclature, that is a——

Mr. MOULTON. So do you think this is a pandemic or not, Deputy Secretary?

Mr. HARGAN. I believe that the WHO has its own responsibility for that nomenclature——

Mr. MOULTON. Do you think that this is a pandemic or not?

Mr. HARGAN. WHO has its own——

Mr. MOULTON. No, no, we will take WHO out of it. Do you think that this is a pandemic or not?

Mr. HARGAN. I believe that whatever we do within the U.S. Government at HHS is the important thing that we focus on. It is providing responses to the American people——

Mr. MOULTON. Just answer the question, Deputy Secretary. Is this a pandemic? The American people want to know, and they deserve to know, and they deserve to hear it from you.

Mr. HARGAN. With response to the declaration of these kinds of terms by the WHO, I defer to them about——

Mr. MOULTON. No, no. I am not talking about the WHO. I am talking about you and HHS. Is this a pandemic?

Mr. HARGAN. The declaration of a pandemic or not, from an American point of view, from an HHS point of view, doesn't——

Mr. MOULTON. One more quick question. The President said that we are very close to having a vaccine. Is that true? Are we very close?

Mr. HARGAN. We are—we—I think Dr. Fauci has said that we are within two to three months, hopefully, of entering a——

Mr. MOULTON. Two to three months.

Mr. HARGAN [continuing]. a vaccine——

Mr. MOULTON. So we are going to hold you to that, Deputy Secretary.

Mr. HARGAN. That——

Mr. MOULTON. Two to three months for a vaccine.

Mr. HARGAN. Two to three months——

Mr. MOULTON. Thank you, Mr. Chairman.

Mr. HARGAN [continuing]. clinical trials.

Mr. MOULTON. I yield back.

Mr. HARGAN. So I just echo what Dr. Fauci said in his testimony——

Chairman YARMUTH. You can go ahead and finish your answer.

Mr. HARGAN [continuing]. to Congress. Yes, so he had said within two to three months they hope to have a vaccine, candidate vaccine, into clinical trials. And after then we would enter into further phases of the vaccine. After that, in terms of preparation for——

Mr. MOULTON. So when can Americans get the vaccine? What is your estimate?

Mr. HARGAN. I think we are going to—we will see what the scientists, the laboratories, and the researchers are able to achieve. But we think that—I think, according to what we have been told most recently, we are going to, hopefully, have a vaccine earlier than we have had vaccines in the past because of the investments that have been made by Congress, by the Administration over the past years in order to prepare us for situations like this.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from Missouri, Mr. Smith, for five minutes.

Mr. SMITH. Thank you, Mr. Chairman.

Thank you, Secretary, for being here. There is so many things that I would like to ask, or even to comment on.

We are here in regards to you presenting the President's budget. And so let's just get some facts out there quickly, and that is the President presented a budget this year, that is why you are here. The House majority Democrats have not presented a budget this year. Last year, President Trump presented a budget. Guess what? The House Democrats didn't present a budget. They like to criticize the President's budget. They like to criticize the budget that you helped with. But they can't even present a budget themselves.

And, just like Speaker Pelosi has said numerous times, a budget is a statement of your values. The reason why the Democrats can't present a budget on this Committee is because they can't get along, because more than half of the Democrats on this Committee are sponsors of Medicare for All. More than half of them are. The cost of Medicare for All is over $30 trillion. That is their solution to health care, Mr. Secretary, Medicare for All. That would cost every household $25,000. Think about that. That is why they don't have a budget, because they can't decide whether to put that in there or not.

I am thankful that you are here at least presenting a budget. I am also thankful that the Republicans, over the last several years, have increased NIH funding by 39 percent. I am also thankful that Republicans have increased funding to CDC by over 24 percent in the last several years. I am also thankful that the President has signed legislation in the last year to help make us better prepared for possible outbreaks like the coronavirus.

However, unfortunately, what I am not thankful for is hearing so many folks on the other side of the aisle try to make coronavirus political because they hate the President. We have had Democrats

that has called coronavirus the Trump virus. That is unacceptable. It is unacceptable.

Sunday, when I was home in my congressional district, a 14-year-old girl died of the flu in my hometown of 5,000 people, a 14-year-old girl. Nine people have lost their lives by coronavirus in the state of Washington. Fifteen people have lost their lives from flu in my congressional district this year. A loss of a life is horrible. We have a vaccine for flu. We don't have a vaccine for coronavirus, and still people are dying.

We have the best health care in this country than any other country in the world (sic). And I know that Americans can pull together and make a difference. And a lot of us don't know how bad coronavirus is. People may act like they do, but they don't. We do know flu is bad. A lot of people is losing their lives. I just gave you the number of how many have lost their lives in my congressional district alone, which is almost double of how many has lost their lives of coronavirus so far.

What is unacceptable is the Democrats have been playing partisan games with coronavirus. They complained when the President asked for an increase of funding and a supplemental of $2.5 billion because they said it wasn't enough, and that we needed it fast. Guess what? Ten days ago, the President asked for that funding and we are still waiting for a supplemental bill to be filed by the House Democrats. They say they need more money.

Last week, instead of doing a supplemental bill, we banned flavored cigarettes. Let's get our act together. The Democrats control this House. Let's put a supplemental on the floor and at least file a supplemental. I would love to see what is in it. Ten days. How many days is it going to be? Is it going to be filed today, or is it going to be a couple of weeks?

I yield back, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired. He will have it before the end of the day, actually.

I now yield five minutes to the gentleman from New York, Mr. Higgins.

Mr. HIGGINS. Thank you, Mr. Chairman. I would agree that we are here to discuss budget facts. So let's talk budget facts.

The budget proposes to cut $1 trillion to Medicaid, which will hurt access to about 13 million Americans. The budget proposes to cut about $500 billion to Medicare. The Administration has said, in relation to these cuts, that the President's budget is not an action item, it is a statement of priorities.

In your biography here, Mr. Secretary, it states that as deputy secretary you are the chief operating officer and are responsible for overseeing the day-to-day operations and management of the Department, in addition to leading policy and strategy development. Are these cuts representative of the President and your priorities?

Chairman YARMUTH. Before you answer, Deputy Secretary, could you pull the microphone closer to you?

Mr. HARGAN. Sure.

Chairman YARMUTH. Or move closer to it. Apparently, C-SPAN is having—people are having trouble listening on C-SPAN.

Mr. HARGAN. Sure. So, with regard to Medicare and Medicaid, which I think you had—you were mentioning, there is no cut, year

to year, in the money spent on either of these programs. In fact, our budget anticipates a growth in the programs every single year—Medicare and Medicaid, for the entire time, the next 10 years. So there are no actual cuts here at all.

In fact, what we are trying to do is slow the growth of these programs, we hope, in a thoughtful way. For example, in Medicaid we took projected growth of spending from 5.4 percent to 3.1 percent. Now, that means that it would be roughly in line with the average salary increase that Americans are projected to have. With regard to Medicare, it is from 7.3 percent growth to 6.3 percent growth.

So we are anticipating growth in these programs, but we are trying to make sure that we are saving these programs in a sustainable way into the future. We know that the Medicare trustees have told us, as we heard earlier, 2026 is a time in which these—the trust fund will start to run out. The reforms that we proposed will extend the life of that trust fund to 25 years, at least. And I think we have to preserve it, not just for today's seniors, but for tomorrow's. It is a promise to the American people.

Mr. HIGGINS. Mr. Secretary, respectfully, the cut is explained in the budget detail that it would be a cut to providers. But those are the very providers that we depend on to provide access to those under the Medicare program. So a cut to those providers will likely result in limited access to those providers.

Also in the budget, the National Institute of—Institutes of Health, which is a very, very important research institution, the largest research institution in the entire world, and includes many component parts that are important to us—the National Cancer Institute, the National Institute for Allergy and Infectious Diseases—there are cuts to these two agencies, as well. Does this represent a statement of priorities for the President and you, as Secretary?

Mr. HARGAN. Well, within the discretionary budget, NIH is and remains the single largest item that we are proposing in our budget. So, in terms of the priorities that this Administration has for its budget at HHS, NIH is our top priority. So it remains our number-one spending item in the discretionary budget. So whether it is a statement of values or just as a matter of fact, we are proposing a—that NIH remains the number-one discretionary spending item.

Mr. HIGGINS. So if it is the number-one priority, why is it proposed to be cut?

Mr. HIGGINS. Within the discretionary budget environment that we are in here, that NIH funding has been increasing at a rate that I think it is hard for our budgets to keep up with, we are trying to reduce federal deficits and debt, and we—and now I think Congress, of course, is going to decide the right spending level——

Mr. HIGGINS. Final question——

Mr. HIGGINS [continuing]. for NIH.

Mr. HIGGINS [continuing]. Mr. Secretary. The President said earlier this year that, "I was the person who saved pre-existing conditions in your health care." The fact of the matter is people with pre-existing conditions have insurance because of President Obama's health care law, which the President, President Trump, is now trying to obliterate through the federal court.

There is only—you know, before the Affordable Care Act, if you had a kid that was stuck with childhood cancer, an insurance com-

pany could deny you coverage because of a pre-existing condition. You can't do that anymore. It is against the law. But there is only one law in America that protects people with pre-existing conditions, and it is the Affordable Care Act.

So if you are trying to obliterate that law with a specific alternative to replace it, you don't support protecting people with pre-existing conditions. I am just curious. How do you reconcile that, sir?

Mr. HARGAN. So——

Chairman YARMUTH. You may answer.

Mr. HARGAN. So with regard to that, as you know, the President has said that that is the centerpiece of whatever reform we would bring forward, and is to protect Americans with pre-existing conditions. And so we reiterate that, as the centerpiece of that. Regardless of what—if Congress has some reforms in mind for existing laws, we would endeavor to make sure that protection for pre-existing conditions is at the center of it, regardless of what form that takes.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from North Carolina, Mr. Holding, for five minutes.

Mr. HOLDING. Thank you.

Mr. Secretary, various national regulatory authorities take different approaches to overseeing the manufacture of drug products. And this is true, even among countries that are part of the International Conference of Harmonization, which produces guidelines that tend to streamline global regulations.

Additionally, regions and countries with regulatory authorities that diverge from the ICH completely may contribute to global risk for drugs supply interruptions by diverting manufacturer time and attention away from establishing quality measures.

So my question to you is how has the FDA worked with the International Conference for Harmonization and the Chinese Government, which is part of the ICH, to align on current good manufacturing practices, standards?

And what is the impact of streamlining these standards on the cost of drug products?

Mr. HARGAN. Yes, thank you. And, as you—as I am sure you know, that—in 2008 FDA established its first foreign office in Beijing to promote international policy harmonization in terms of regulating drugs that are coming into the American market from China.

So between harmonization and regulatory convergence, we have a China office there. It is currently working with local drug manufacturers on quality improvement. And that is going to believe—we believe that is going to help facilitate first cycle approval of generic drugs, which is consistent with the FDA's goals overall, and the record numbers of generic drugs that have been approved each of the last three years.

Now, since June 2018, China has been involved with the International Council of Harmonization. They have been nominated to join the management committee. Now, that gives us great hope that, if China is part of the ICH in a thorough way, that they are going to join in those harmonization efforts, and we are going to

be able to help facilitate their entrance into joining international standards, which FDA and others of our peer countries have been working for years on trying to harmonize the regulatory structure and making sure that drugs produced anywhere are going to have the highest level of quality.

So what we have been able to see is that they are attending meetings, we are having conversations, sending technical experts to these international forums. Now, the ICH, we believe, has kept pace. The membership criteria for them is robust. So China, to get entrance into that, is going to have to implement a basic set of regulatory requirements for the manufacture of pharmaceuticals, for the conduct of clinical trials in China, and for stability testing of pharmaceutical products. So, with their entrance, they have to hit those requirements.

And so, you know, we are looking forward to seeing how that is accomplished, which will accomplish greater quality improvements on things sourced in China.

Mr. HOLDING. Good, thank you. Now, I have been encouraged by the Administration's effort to improve treatment for ESRD patients through the 2019 executive order, Advancing American Kidney Health Initiative, as well as the ESRD Treatment Choice model proposed last year, aimed at providing patients more choices through moving to dialysis at home or a transplant. Kidney disease has a significant impact, as you know, on Americans' everyday lives, and makes up more than $1 in $5 spent by the traditional Medicare program.

So my question, Mr. Secretary, is do you anticipate that you finalize the ETC model in the next few months, and can you speak to the savings that this model is expected to generate?

Mr. HARGAN. Yes. We are working internally on that model, as you know, right now. So we are—while I don't want to perhaps give any particular timing on that, it is obviously—kidney health is a serious priority for the President. As you point out, it is about 20 percent of the spending in some of our programs at HHS. And it is a serious—not just a financial, but a physical drain on people who are in dialysis treatments. So we are working to stand that out.

These are sort of—these issues, as you know, go back decades with regards to how we treat and reimburse patients in this area. In many cases it has been, I think, a galvanizing moment for this part of the health care sector, that we have new models being proposed. So we hope to have something out, as I say, as soon as we can, making sure that we get a thoughtful and successful launch of a model.

Mr. HOLDING. Thank you. I have another question, which I will submit for the record, regarding the Pharmaceutical Cooperation Inspection Scheme and the mutual recognition agreement with the European Union and the Australia, Canada, Singapore, Switzerland Consortium. But I will send that to you in writing, as I am out of time.

Thank you, Mr. Chairman.

Chairman YARMUTH. I thank you.

Mr. HARGAN. Thank you.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from New York, Mr. Morelle, for five minutes.

Mr. MORELLE. Thank you, Mr. Chairman, very much for holding this important hearing today. And thank you, Deputy Secretary, for—I know, it is hard to find where we are, right?

Mr. HARGAN. Yes.

Mr. MORELLE. Thank you. I am over here. And thank you, Deputy Secretary Hargan, for being here.

Mr. Secretary, as you may be aware, in November of last year the Department of Health and Human Services denied the state of New York's request to renew its delivery system reform incentive payment called DSRIP, for short. It had a waiver. We wanted to extend it past March, and that has been denied.

DSRIP is a Medicaid redesign program dedicated to fundamentally restructuring the health care delivery system by reinvesting in the Medicaid program with the primary goal of reducing avoidable hospital use by 25 percent over five years. So the idea is, rather than using sort of a slash and burn technique to cut health care costs, DSRIP provides a comprehensive and sustainable approach that takes preventive measures to identify the needs of our most vulnerable population before treatment becomes incredibly costly. And much of that involves the social determinants of health.

For example, suffering from congestive heart failure is expensive, obviously frightening, and requires regular medical attention. If you add to that the question of stable housing for the patient, and you add that into the equation, you really are now dealing not only with extensive concerns that you might have about your health, but you are also having to do it while you are worrying about whether you have a roof over your head, working to keep food on your table, paying for prescription drugs, et cetera, et cetera. And simply getting to a doctor's appointment becomes a—both a physical and emotional and financial drain and challenge. So—and you are forced not to choose simply between your immediate stability, but also your long-term health and the cruel and unsustainable situation that it puts people in.

So DSRIP funds programs that New Yorkers and patients throughout the country who have complex medical issues—allows them to address those needs. The dollars were allowed under the federal waiver to assist people with complex affordable housing issues, arrange medical transportation, and dealt with things like opioid addiction, childhood asthma, a whole host of programs and projects that were undertaken by the various DSRIP provider networks throughout the state.

Since the implementation of it, hospital admissions have been reduced by 21 percent among the Medicaid population that was targeted, and preventable readmissions reduced by 17 percent, according to numbers that I have from June 2018, the last data that is available.

This budget cuts Medicaid, it stops the waiver program. And in effect, in my mind, while you can get short-term gains perhaps in terms of financial gains, the outcomes are going to be dramatically reduced and, in fact, cost us, long-term, far more money, money that people in the health care field are often trying to get to the

quadruple aim, which is better outcomes, bending the cost curve down, having improved patient experience, and improved provider experience.

And I am very, very troubled that this budget doesn't take into account many of the advances that are made toward achieving the quadruple aim and using social determinants to achieve better outcomes. And I want to know whether or not the Department would reconsider New York's DSRIP waiver application.

Mr. HARGAN. With regard to the particular waiver application, we can certainly talk to you after this. But I wanted to talk a little bit about social determinants of health.

I think we completely agree that these are issues that we have tried to stand out on in terms of developing thoughtful policies dealing with those. We know that, in many cases, they can be very helpful to people, and can help avoid some of the hospitalizations, some of the further medical problems that take place down the line, that there are—and some of the flexibilities that we have tried to allow people to have in spaces for plans to be able to work them into their own plans, we think, is very helpful.

Some of the things like the Stark and anti-kickback reforms that have been proposed would allow social determinants of health to be worked on, among——

Mr. MORELLE. So——

Mr. HARGAN. So some of the regulatory——

Mr. MORELLE. Yes.

Mr. HARGAN [continuing]. reforms are very much aimed in that direction.

Mr. MORELLE. Well, let me—and I appreciate that. I would suggest this, and I apologize because I only have just a few seconds left, and this is probably less in the form of question than just a comment on it. I would suggest that, in the short term, the next 36 months, that we would have to make significant new investments in Medicare and Medicaid to have real redesign of systems that allow for the longer-term changing of the cost curve down and improving those outcomes dramatically.

And I would like to work with the Department on thoughtful ways to increase investments to have longer-term savings, again, improve outcomes, avoid admissions, avoid re-admissions, and improve patient experience and those of providers who are struggling under shortages to deal with the stresses of their job.

So I appreciate you being here, and I would like to continue the conversation, if we can, offline.

Thank you, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from South Carolina, Mr. Norman, for five minutes.

Mr. NORMAN. Thank you, Chairman Yarmuth.

Mr. Secretary, thank you for coming. Before I ask my question, I would like to yield 60 seconds to Congressman Stewart.

Mr. STEWART. Thank you, Mr. Norman. And I won't take 60 seconds, being respectful of your time.

Mr. Deputy Secretary, thank you for being here. I did have a question, but many of us are trying to de-conflict schedules here, and I can't stay.

There is a company in my district called Navigant. I am aware of other companies, as well, that think they have solutions, or partial solutions, or potential solutions regarding the coronavirus. And I am sure you are aware of some of these.

What I would like to do is just submit, in writing, for the record, the agency's plan to develop and to leverage these public-private partnerships. Very clearly, the answer is going to come from some private company somewhere. Are we—do we have a highway, a way of integrating with these companies, and to get the information from them that otherwise—you know, in a very time-sensitive manner?

And again, we will submit that for the record.

Mr. HARGAN. Yes.

Mr. STEWART. Thank you, Mr. Norman.

Chairman YARMUTH. May I ask the gentleman, do you have something you want submitted for the record?

Mr. STEWART. Yes.

Chairman YARMUTH. OK.

Mr. STEWART. If we could.

Chairman YARMUTH. I couldn't quite figure out whether you wanted him to submit something in response——

Mr. STEWART. No, my—if I misspoke, I apologize.

Chairman YARMUTH. That is all right.

Mr. STEWART. Thank you.

Chairman YARMUTH. Without objection, so ordered.

Mr. STEWART. Thank you.

Mr. NORMAN. Thanks.

Deputy Secretary, one of the most frequent calls I get is pricing for pharmaceuticals. "Why is my insulin price so high?" Why is a particular type drug—what—PBMs are of great interest to me. The spread pricing that—where they reimburse pharmacies one price, charge the state an astronomically higher price, what can—I guess—can you give me a road map for what you consider a way to bring a light to that to help our consumers?

Mr. HARGAN. Well, as you know, the President has made bringing down the cost of pharmaceuticals one of the keystones of what we are trying to do at HHS, and put out—early on in Secretary Azar's tenure we put out a blueprint addressing drug pricing, which had dozens of different proposals that we are standing out, in terms of addressing drug pricing.

The—some of the things that we have done—one of the things that we have done just internally at the Department is the fact that the generic drug approval rate has gone up to record levels. We have also had high numbers of innovator drugs that have been approved. All of those things, just kind of—of their nature, by producing competition, produce lower costs for Americans.

So we have seen drug prices—and Americans use generics in large numbers. So we have seen prices lower as more generics come online. That is a huge help, and that just happens in the day-to-day business of the Department, but now at record numbers, thanks to some of the reforms that were put in place.

On top of that, we have other proposals, things like the direct-to-consumer rule that has been put out that says—that shows peo-

ple the prices that they are going to be charged. We think that would have some effect on drug prices, as well.

We also are very happy to engage on drug pricing proposals that Congress has put forward to move forward on a bipartisan, bicameral basis, to have legislation that can enable Americans to get lower prices for drugs. We have endorsed a number of different areas in that space. However, we know that Congress has a lot of different potential proposals in here, and we would be happy to work with people here on that basis to bring forward good legislation in this area.

Mr. NORMAN. Well, I appreciate it. You know, when I—when you get calls from those widows whose child has been diagnosed with diabetes, and the question is, "How can afford the insulin," because the alternative of her dying, it has an impact on you.

Mr. HARGAN. Yes.

Mr. NORMAN. So—and I appreciate the Administration's goal to keep the focus on that. And it is real, I can tell you, in the real world.

Mr. HARGAN. Yes. Yes, absolutely. And, you know, we have done some reforms. Part D premiums have come down over 13 percent in the past few years. So you are seeing the impact in areas on there. That doesn't mean that we stop, just because we have had some successes in bringing down premiums and bringing down prices. We still have areas where we need to focus.

And, you know, insulin is one of the areas that—we hear a lot of public testimony on that very issue. So we are committed to working with Congress on these issues.

Mr. NORMAN. Well, I appreciate it. And insulin is one—is—the question I had from my—from the person who called me was, "This has been—people have had diabetes for a long time. Why is the drug that should be a lot cheaper than it is, why am I having to pay the price that I am?"

I have got 30 seconds. What about—I have got a lot of rural communities with sovereign Indian tribes. Access to health care, what is your take—opinion on getting them easily accessible medical care?

Mr. HARGAN. So with regard to rural areas, we have a lot of different proposals. The Secretary, about a little over a year ago, put together a rural health task force internally at the Department. And so we have been working to get together a package of proposals to work on with regard to rural health.

So expanding access in there is going to take both the areas technologically, like telehealth, which we have talked about already, but also being able to have a good work force in the area, where people can practice to the top of their license, and we have access to care, both on the service side as well as the technological side. Both of those areas are going to require reform.

We—some of it is going to require reimbursement reform, and we have advocated for some of that, and have enacted some of that, but it is going to require a—probably a longer conversation. Fifty-seven million Americans live in rural areas. They have—there is a disparity between rural America and non-rural America, in terms of the health care that they get on basic things like heart disease and cancer.

So—and we are going to have to move to a model that is going to enable rural Americans like myself, as I grew up, to have access to care, to have access to quality care that they deserve. And some of that is going to be, as I say, technological. Some of it is going to be work force development that is going to enable us to move forward into a new model of rural health care that is going to allow Americans to get better care.

Mr. NORMAN. Thank you for your service.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from Nevada, Mr. Horsford, for five minutes.

Mr. HORSFORD. Thank you very much, Mr. Chairman. And thank you, Deputy Secretary, for being here today.

I want to point out just before I begin, several of my colleagues throughout this morning have talked about the budget and the President's budget proposal, the congressional budget. But I just want to reiterate that there are budget cap agreements in place through 2021 that have been agreed to with the Senate, with the House, and the Administration. In fact, the Ranking Member of this Committee and member—many members on the other side voted for those budget caps. So I know we get a lot of misinformation from the White House, but I just wish that we would not bring that misinformation into this Committee setting.

Mr. Deputy Secretary, last week your boss, Secretary Azar, came before the Ways and Means Committee, and I asked him about the Administration's proposed $52 billion cut to the graduate medical education program. Today these cuts would have detrimental impacts on my home state of Nevada, where we need more physicians, not drastic cuts to the very program that trains and retains our doctors, particularly in this environment with the coronavirus, where some of our doctors who are being exposed are no longer available.

So my question to you specifically related to this is Nevada ranks 48th in the nation for primary care doctors. We have about 180 full-time doctors in southern Nevada per 100,000, compared to over 303, on average. And in certain parts of my district I, literally, don't have an adequate number of OB-GYN providers. We have 259 in the entire state of Nevada.

So what is your take on the proposed $52 billion of cuts to the GME program?

Mr. HARGAN. Well, I think that the point that you made about the lack of OBs, for example, I was—my parents are—and I am—from southern Illinois, but I was born in Missouri because there wasn't even an OB available in rural southern Illinois at that time. So——

Mr. HORSFORD. So why is the Administration cutting the very program that trains more doctors, including OB-GYNs?

Mr. HARGAN. One thing that we have done is, by turning this into a more flexible block for GME, we have incorporated a lot of the GME money into a single program. That is going to allow——

Mr. HORSFORD. Reclaiming my time, because that is the exact statement that the Secretary gave me in the other committee. And somehow he argued that cuts to a critical training program would be good for states like mine. And that simply is not true.

Not only would my state lose funding for new doctors under this budget, the plan outlined in your budget would hurt the 630,000 Nevadans who are covered by Medicaid. Both the American Academy of Family Physicians and the American Medical Association put out statements opposing the Administration's proposal, and have warned that it would lead to significant benefit cuts, would require states to limit the number of beneficiaries receiving coverage, and it would put vulnerable populations at greater risk.

We are a growing state. Putting us into a block grant program and calling it flexibility doesn't work. So I am unclear. How does a proposed flexible fund, which is just a block grant program, and which adds no additional funds to the training of doctors in my state or any others, how does that help constituents have access to more doctors?

Mr. HARGAN. So when you talk about exactly what GME has done so far, we haven't had a real revision of this law in terms of, like, what types of doctors that it funds since, I believe, 1996 or 1997——

Mr. HORSFORD. So will you work with us on that?

Mr. HARGAN. Yes.

Mr. HORSFORD. To address the need to diversify the revenue that funds the GME program?

Mr. HARGAN. I think that——

Mr. HORSFORD. So that we are not just relying on CMS funding?

Mr. HARGAN. Yes, and I would say that one thing that we are trying to do here in the reform is to move it out of being funded by the Medicare Trust Fund, which we think is a place where seniors are actually using some of the Medicare money that has been set aside for them to fund GME, which, in many cases, funds doctors that aren't actually Medicare doctors——

Mr. HORSFORD. So you agree to work with us to come up with a more robust GME program so that we can train more people, and meet the needs of our constituents that need to see doctors?

Mr. HARGAN. And update the GME program, so it represents——

Mr. HORSFORD. Is that a yes?

Mr. HARGAN. Yes, we would like to work with you.

Mr. HORSFORD. Great. The Administration also proposes a nearly $1 trillion cut to Medicaid over 10 years. How will these compounded cuts impact my constituents' ability to lead healthier lives and access physicians that they need?

Mr. HARGAN. We think there won't be any cuts to Medicaid at all. There will—every year there will be an increase in payments in Medicaid. We anticipate all that we are doing here is putting in place reforms that are going to slow down the rate of growth to make sure——

Mr. HORSFORD. Slow down the rate of growth in the effect——

Mr. HARGAN [continuing]. it is a sustainable program.

Mr. HORSFORD. In effect, cuts $1 trillion over 10 years. Let's be honest with what it does. We get a lot of disinformation and misinformation. Let's not continue to do that in this Committee.

Thank you, Mr. Chairman, and I yield back.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from Tennessee, Mr. Burchett, for five minutes.

Mr. BURCHETT. Thank you, Mr. Chairman, Mr. Ranking Member. Although our Ranking Member has decreased in age, he has not increased in good looks, and I would like to state that for the record.

Thank you, Mr. Hargan, for being here today. And I would like to ask about—focus on Medicaid as it is today in Tennessee.

Do you think Washington or state governments are better equipped to design programs that are best suited to their individual state?

Mr. HARGAN. The states, obviously. That is the whole premise of the Medicaid program, is that the states run the programs for their own populations.

Mr. BURCHETT. Great. As you know, my home state of Tennessee is the first state to convert our current Medicaid program, TennCare, into a block grant. What would the impact of this budget have on this new direction my state is going?

Mr. HARGAN. Well, we are, I know, looking—working with Tennessee on their proposal and what they have done. And, again, Medicaid rises every year. The amount of money that is set aside for Medicaid in this budget goes up every year. So we would anticipate that the money would go up for Tennessee, and that those flexibilities that would be available under any proposal are there for Tennessee to—for its own population, and for the needs that they see locally for their state.

Mr. BURCHETT. OK. I have no more questions, Mr. Chairman. I will yield back the remainder of my three minutes and 32 seconds.

Chairman YARMUTH. Thank you, sir.

Mr. BURCHETT. You are welcome, sir.

Chairman YARMUTH. I won't even say your time has expired. You yielded it back.

I now yield five minutes to the gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Deputy Secretary Hargan, when President Trump ran for office, he made a promise. He said, "I am not going to cut Social Security like every other Republican, and I am not going to cut Medicare or Medicaid." However, in almost every one of the budgets that he has released since taking office he has proposed slashing hundreds of billions of dollars from Medicaid and Medicare and Social Security. For Fiscal Year 2001 (sic) you have proposed cuts of half-a-trillion dollars from Medicare, almost $1 trillion from Medicaid, $25 billion from Social Security.

These programs keep seniors, individuals with disabilities, and their families alive. And they are critical as we battle coronavirus right now. Medicaid covers the care of six in 10 nursing home residents, who are often older and living with chronic medical conditions putting them at high risk, as we have seen in Washington State.

While your Administration recently requested $1.2 billion in new resources to fight coronavirus, the supplemental request did not address $900 billion in cuts to Medicaid and—from—as was in the original proposal.

So you may say that you were unaware of the coronavirus in scope when you wrote that budget. But clearly, we have a problem right now. So what steps or policies are you taking to reduce the

spread of coronavirus among nursing home patients, which is a boiling question right now, or other vulnerable populations who live in a congregate residence setting?

Mr. HARGAN. Thank you, Congresswoman. We are, right now, as Dr. Schuchat of CDC mentioned, Administrator Verma, who oversees nursing homes, has appointed a liaison to work with CDC to make sure that CDC's practices and nursing homes are brought directly into CMS. So they are working closely on the issue about nursing homes. As we had seen from Washington State, that is an issue of the highest priority.

Because this—because the disease, from what we have seen so far, really afflicts particularly those who are both elderly and medically frail, that is why we need to make sure we focus on that, as Dr. Fauci said.

Ms. SCHAKOWSKY. So are you regretting, I hope, that—this almost $1 trillion cut in Medicaid at this very moment, when six out of 10 people in nursing homes require help from Medicaid?

Mr. HARGAN. Well, there are no cuts to Medicaid in the budget. Every year the money—the dollars to Medicaid go up every year in this budget. Same for Medicare. We are simply talking about decreasing the rate of growth to an amount that the average American's wages go up every year, as we expect.

So if we reduce those, what we are doing is preserving it for future Americans. The Medicare trustees tell us the Medicare Trust Fund is going to start running out of money in 2026——

Ms. SCHAKOWSKY. You are talking about Medicaid.

Let me finally—over the past two weeks I urged Secretary Azar, by a letter that was signed by 45 other Members, to ensure that the coronavirus vaccine or treatments that may be found will be affordable, accessible, and available.

And just yesterday President Trump met with the—with a group of pharmaceutical executives. And so I am wondering, do you have any update on the arrangements that have been made with the pharmaceutical corporations and other private-sector partners around licensing and pricing of the COVID–19 vaccine?

Mr. HARGAN. Well, we—as you point out, we are working with the private sector to develop and test a COVID–19 vaccine. Government scientists invented some of the vaccine's critical aspects, and we intend to work with the companies to ensure that the price they charge the government for the vaccine is affordable for taxpayers and patients, as well.

Ms. SCHAKOWSKY. Thank you, and I yield back.

Chairman YARMUTH. The gentlewoman's time has expired. I now recognize the gentleman from Pennsylvania, Mr. Meuser, for five minutes.

Mr. MEUSER. Thank you, Mr. Chairman.

Thank you, Deputy Secretary Hargan, for being with us. I represent a relatively rural congressional district, and I have concerns related to CMS's so-called competitive bidding program, particularly related to rural areas.

CMS issued an interim final rule in May 2018 that provided payment relief for durable medical equipment in rural areas, and has continued the relief until the end of 2020. Mr. Secretary, can you

tell me if CMS plans to continue this relief in rural areas after 2020?

Mr. HARGAN. Well, we do know that we are in the bidding process right now for the competitive bidding program, and that we—as you pointed out, with the IFR that was issued we granted—there was some granting of relief by the agency on that. We are hoping that this is going to alleviate a lot of the problems that are faced by suppliers in that area.

We do know that there are issues in rural areas where the number of suppliers continues to decline in that space, which creates particular issues for competitive bidding in rural areas. So I think we look forward—we are going to be continuing to work in this area to figure out how to come up with solutions for rural areas that have declining numbers of providers in this area of DME.

Mr. MEUSER. Well, that is excellent to hear. I spent quite a number of years in the medical equipment industry, and I feel, as many do—and I think stakeholder groups and consumer groups—that very often competitive bidding is very much of a misnomer. It is really more of the lowest price, regardless of quality, patient choice, who the supplier might be, provider or supplier standards, and distance to travel usually is not often enough taken into consideration.

So when any—and it sounds like you know a thing or two about it, which is encouraging. Before any such decisions are made, you do plan on having a stakeholder input?

Mr. HARGAN. So with regard to winding CMS and issues like this, it is definitely being considered by the Rural Health Task Force that we have drawn together. That looks at, sort of, rural health and the problems that are faced by it from the point of view of all of our agencies, including CMS, including HRSA, the Indian Health Service, and others that deal with these—that deal with the issues of getting rural access to care. So DME is one of those issues. Obviously, CMS has taken action on this to provide relief, but we are looking forward to getting a comprehensive package of reforms together in this area, and getting them out.

Mr. MEUSER. Again, very encouraging. That is good to hear.

In the 2021 budget there is a provision that would expand the competitive bidding program for DME into rural areas in 2024. Is this something that you believe CMS plans to move forward with——

Mr. HARGAN. Well——

Mr. MEUSER [continuing]. without congressional approval? Can you tell me anything more about that?

Mr. HARGAN. So I think, as of now, we are planning on basing competition on the rural areas, rather than on urban areas, which we think is probably better representative of what the conditions are in those areas. So we think that that has attempted to de-link in some ways the competition from areas that probably were inadvertently providing issues for rural areas.

So—but we would look forward to further engagement from the community on this, as we move forward, as I say, with an overall package on rural health care reform.

Mr. MEUSER. Thank you, Secretary.

Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman yields back. I now—you ready?

I now recognize the gentlewoman from Texas, Ms. Jackson Lee for five minutes.

Ms. JACKSON LEE. Excuse me, Mr. Chairman, thank you. Thank you very much.

And to the Deputy Secretary, I appreciate you being here. I just came from the airport in light of some civic responsibilities on Super Tuesday.

And so I am just coming from home, where people are grappling with the coronavirus. I think you are well aware of what people who are beyond the Beltway are thinking.

I want to ask specifically the issue of your proposal originally to cut CDC's discretionary budget by nearly one-fifth and its overall budget by 9 percent, or $700 million. If enacted, how would these cuts affect the CDC's ability to respond to the future global epidemics?

Now, let me say that I know that budgets are prepared over a long period of time. But I also know that it was not finalized before there was an indication that there was a major epidemic in China. And I am baffled how the Administration could send forward a budget that would do such drastic things.

I also want to—let me match this question of how did the HHS—so these are two together—determine that that amount was sufficient, the $1.25 billion was sufficient to fully address the scale and seriousness of the coronavirus epidemic?

And what activities would HHS not be able to carry out, if that $535 million were repurposed?

Mr. HARGAN. Thank you for that. The cuts that you talked about that were indicated, they were—we actually increased the funding for infectious disease response at CDC by $135 million. So we had actually already increased funding for these specific areas in the budget that was proposed. So CDC's funding would go up this year——

Ms. JACKSON LEE. But only in the infectious diseases area.

Mr. HARGAN. And that is the area that we would use for the coronavirus——

Ms. JACKSON LEE. Right.

Mr. HARGAN [continuing]. issue that you indicated——

Ms. JACKSON LEE. But that is not all that they do. I did ask a specific question. But go ahead, let me let you finish.

Mr. HARGAN. Yes. And with regard to the $2.5 billion supplemental that was brought forward last week by the Administration, we—as the President said, we are open to discussions with Congress about this. I think he said very specifically about that. So, with regard to the number that Congress proposes on that, we are absolutely willing to work with you all flexibly on that front.

Ms. JACKSON LEE. Mr. Deputy Secretary, with all due respect, don't you think it was somewhat derelict for the Administration even to think about reducing funding for CDC and NIH? And I think it was a combination of $3.58 billion and then another $658 million, if my numbers are correct, for the NIH. Don't you think that was not responsible, in light of the fact that you had the backdrop of the issues dealing with the coronavirus?

Mr. HARGAN. Well, NIH is the largest element of our proposed budget in discretionary spending. So it is—and by far. So, in operating within the budgetary environment that we have, we had to approach it with the point of view of prioritizing the areas that the—that NIH wanted to prioritize, things like artificial intelligence and other areas that they were standing forward. But it is the largest element of a discretionary funding.

When we are in a situation where we have to give thoughtful reforms to our discretionary budget lines, NIH, as the largest element, naturally ends up with some reductions. But with regard to infectious disease, we have definitely already—in that environment, already increasing the funding for the elements of CDC that would provide response.

Ms. JACKSON LEE. My time is running quickly. Let me ask this question again.

Life expectancy before the passage of the Medicare legislation was 70 years and, after that, 72 years and growing. What came over the Administration to have a $1.7 trillion—I think that is the number—cut in Medicare and Medicaid?

And the President made a very loud proclamation as he was running that he was prepared to work very hard to help with the decreasing of prescription drug costs. We have seen no efforts on behalf of the President at this time and in HHS to do so. And they are certainly not advocating for H.R. 3.

What is your reason for the huge cuts that will go to my constituents and others across the nation in Medicare and Medicaid, and—as well, doing nothing about lowering the cost of prescription drugs?

Mr. HARGAN. We are projecting increases every year in Medicare and Medicaid in dollars spent in these programs every single year.

Ms. JACKSON LEE. I am sorry, I didn't hear that. What did you say?

Mr. HARGAN. We are projecting increases in dollars spent in Medicare and Medicaid every single year, including the upcoming year, and every year for the next 10 years within the budget, within the budget cycle.

What we have proposed is what we hope are thoughtful decreases in the rates of growth of both of these programs so that they don't grow as quickly. Part of that is what we want to do to create—make sure that the promise of these programs that we all agree on, Medicare and Medicaid, are available to future generations of Americans. We don't want the Medicare Trust Fund to run out in six years, as is projected. We want it to be available, we believe on current projections we will get 25 years out of the Medicare Trust Fund.

So at some point we have to do—make some reforms——

Ms. JACKSON LEE. Can you move to the prescription drugs inactivity?

Mr. HARGAN. Sure. Part of the way that we have tried to reduce the cost of drugs is actually internal to the Administration. By increasing the number of generic drug approvals, that lowers the cost of drugs overall. The more generics we have out there, the more Americans have access to generic drugs that are far lower in cost.

We get—we also have increases in the number of innovator drugs that compete with existing drugs out there. So those also help reduce the cost there.

We have—the drug pricing blueprint has dozens of proposals that the Administration has stood forth, or is planning to stand forth to reduce the cost of drugs. It is a centerpiece of what the President wants to do for Americans. And we look forward to working with Congress, on a bipartisan, bicameral basis, to bring forward legislation that addresses this issue.

We agree with you, it is a top issue of mind for——

Ms. JACKSON LEE. Chairman, I just have a question. I know that my time has ended.

Chairman YARMUTH. No——

Ms. JACKSON LEE. I just want to ensure that we can dig deep in the $1.7 trillion cut and why there has been no direct response to the legislation that has been offered by this Congress on lowering prescription drugs.

Chairman YARMUTH. Duly noted. The gentlewoman's time has——

Ms. JACKSON LEE. I yield back, thank you.

Chairman YARMUTH [continuing]. expired. I now recognize the gentleman from Texas, Mr. Roy, for five minutes.

Mr. ROY. I thank the Chairman very much. Mr. Hargan, thanks for being here.

The reason there has been no response to H.R. 3 is because it would devastate innovation. It would destroy the ability of the market to produce the drugs that are saving lives throughout the country, including the drug, for example, that helped save my life when I was going through cancer at MD Anderson. I think we want to make sure we promote a market where we can have the kinds of drugs that are saving lives and not destroy it, which is exactly what H.R. 3 would do.

With respect to spending, I would like to ask you to repeat again. Is there a single decrease in Medicare or Medicaid expenditures in the proposed budget from the President of the United States?

Mr. HARGAN. There is—there are increases in Medicare and Medicaid——

Mr. ROY. Correct.

Mr. HARGAN [continuing]. every year in the proposed budget.

Mr. ROY. Thank you. And can you tell me the amount that is proposed for CDC spending in the House Democrats' proposed budget?

Mr. HARGAN. I don't know that I have seen a proposed budget.

Mr. ROY. You haven't seen a proposed budget from House Democrats. Yes. That is what I think. There is no proposed budget from my House Democrat colleagues. They want to take pot shots at the President's budget, when the budget proposed by the President is increasing spending on Medicare and Medicaid, yet will not do the hard work of putting pen to paper to actually put forward a budget. That is the reality of what we are dealing with here in this room today.

And so, with respect to the President's budget, and we are talking about savings, you are talking about spending going up on Medicare and Medicaid. Now, why is this a problem?

Health care costs are significantly driving our deficit spending. Would you agree?

Mr. HARGAN. Yes.

Mr. ROY. So in 2019 we had $1.5 trillion in Medicare, Medicaid, SCHIP health care spending. Proposals I have seen, or projections I have seen, by 2030 we would have $2.5 trillion of that same spending. Does that sound right to you?

Mr. HARGAN. I would have to look the numbers over, but yes, they are—the numbers are enormous.

Mr. ROY. There is a massive increase going up.

Mr. HARGAN. Yes.

Mr. ROY. In 1970 mandatory health care spending was 0.8 percent of GDP. In 2020 it is 5.4 percent. In 2030 it is projected to be 7 percent of GDP. We have to be—have serious proposals in this body to deal with these issues, and I appreciate that the President and HHS has put forward a budget that tries to approach balance, even though it assumes 3 percent economic growth and low interest rates.

But you have to have strong economic growth in order to drive out of this. Yet right now what we have is a bunch of political shots being taken in this Committee for no value for the American taxpayer, for no value for our American citizens. We are not sitting down and rolling our sleeves up to figure out what to do about Medicare and Medicaid. We are on a train heading to a cliff, and we all know it. Yet we sit here and do nothing about it.

And my Democratic colleagues refuse to put forward a budget, and take pot shots at the President's budget, which balances, increases dollars for Medicare and Medicaid, and then has cost savings. Let's talk about the cost savings.

GAO just had a report that came out the other day about $175 billion of improper payments, of which $103.6 billion were from Medicare and Medicaid. Are those the kinds of savings you are looking to try to achieve to keep overall spending down, but yet preserve Medicare and Medicaid?

Mr. HARGAN. Yes, we are looking at improper payments, waste, fraud, and abuse, broadly across our programs. That is an important element of this, for us to be able to reform these programs.

Mr. ROY. One thing I would like to point out with respect to pre-existing conditions. Somebody was making a comment earlier about how the President doesn't seem to be concerned about pre-existing conditions. You answered that question, I think, appropriately.

I would note that I saw a report today in social media that investors see the bump in Vice President Biden as stability, and that we wouldn't necessarily get Medicare for All. But here was the little important footnote, that it will keep insurance and pharmaceutical stocks fat, because what Obamacare really is, and what the ACA really is, is the make-insurance-companies-richer bill. It is keep allowing insurance companies to run our health care, because that is what Obamacare is really doing, shoving millions of people on Medicaid, putting more decisionmaking in the hands of insurance companies to run our health care, and then everybody pat themselves on the back while they drove people out of the individual market, increased prices 60 percent across the market, double—triple the premiums for people in the individual market.

That is the legacy of Obamacare. That is the legacy of putting more power in the hands of the federal government deciding health care decisions.

Mr. Secretary, let me just make one point about the coronavirus, if you would. I had a great conversation over at ASPR with Secretary Kadlec, but I did have one troubling—I represent San Antonio. And one troubling take-away from our conversation was I saw no plan on what to do with the citizens who were flown to San Antonio. In other words, there was an assumption by DoD and HHS that citizens that were flown to San Antonio into the bases at Lackland would then be put into civilian hospitals in San Antonio.

Then we had the CDC release an individual who we know who had been exposed, and had exhibited symptoms, and had tested positive, and was prematurely released, endangering some of the citizens of San Antonio.

Can you please offer me some assurances that we are on top of this, that CDC will not make an error like that again, and, most importantly, that the citizens of San Antonio will be consulted prior to decisions being made about how people are going to be released into our communities?

Mr. HARGAN. So, with regard to the CDC protocols, they have looked at that particular case, where they—they had followed the existing protocols, which said that you have to have, you know, the existing amount of time be spent in the quarantine. Plus, there were two negative tests. She had received two negative tests, but there was a pending test outstanding. They hadn't been sequential.

So she was released. It turns out that that positive test was not—I don't believe it was accurate. And so there wasn't a problem, as it turned out to be.

However, they have revised their protocols——

Mr. ROY. Yes.

Mr. HARGAN [continuing]. so that the negative tests will now be sequential.

And then also, if there is a pending test, that somebody won't be released until that pending test result is received. So that should manage this around the particular issue that was received there.

So, other than that, the protocol was followed, globally agreed, 14 days of quarantine for the people who came over.

With regard to the use of the DoD facilities, I spoke myself to the mayor, also to some of the local leaders at—in San Antonio to talk through whatever concerns that they had. So we have been trying to do outreach to local leaders, whether it is senators, city councilmen, local leaders of any kind, and we are going to continue. We are going to continue to do that.

We are also talking to Congressmen and senators at places where there are—but as we move into the next phase of what we are going to be dealing with with coronavirus, I don't know that we are going to anticipate the same kinds of issues that you are pointing out there, with regard to the bases.

Mr. ROY. And Mr. Chairman, with your indulgence, I just want to thank the Secretary and thank you for your responsiveness, generally, at HHS. I can't say the same about DoD, by the way.

Secretary Esper, if you are listening, I am still waiting on a response.

But thank you for that input. Thank you for reaching out to San Antonio. Just keep in mind it is important to have that plan ahead of time, to know—don't assume we are going to put them in civilian hospitals. San Antonio is happy to be at the center of trying to deal with natural emergencies and help our fellow American citizens. Bring them to Lackland, that is great.

Mr. HARGAN. And——

Mr. ROY. But let's just have a conversation if we are going to assume they are going to civilian hospitals.

Mr. HARGAN. Yes.

Mr. ROY. Thank you, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from California, Mr. Khanna, for five minutes.

Mr. KHANNA. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here. My district in Santa Clara County, California, has 11 cases now of coronavirus. And so I want to ask you a few questions to see how we can work together to solve this. That is the only thing that people care about.

First, I am concerned that CDC has stopped reporting the number of tests they are doing on their website. Do you know why that is? And can we get CDC to start reporting on their website again the total number of testing?

Mr. HARGAN. Well, I think that, with the dispersal of testing to a lot of public health labs, and also the fact that we foresee an availability, as Commissioner Hahn has said, of a large number of tests being available from private—from the private sector, we think that there are going to be a lot more testing going on with that, with that particular——

Mr. KHANNA. But can we just have them report? I mean we are the United States of America, not China. We believe in transparency and getting the facts out. Can we just make sure the CDC is actually reporting the number of tests they are doing, or—and all the information they have?

Mr. HARGAN. We will work with CDC about exactly what they are bringing forward.

Mr. KHANNA. Thank you. If you could, talk to them about the reporting.

The second thing I don't understand—again, because we are the United States of America—is how have we only done 472 tests, while South Korea has done 100,000 tests already, and Italy 23,000. I mean, we should—we are the most innovative nation in the world. We have the most resources. How do we make sure that we are getting tests out there, and leading in this?

Mr. HARGAN. In this case there has been no backlog in terms of tests presented to CDC. So that is the good side, that we have not had backlogs. The number of tests, there have not been any delays in terms of tests being presented to CDC, or backlogs of any kind.

With regard to that, before the end of this week we are—as CDC has indicated, we should have public health labs throughout the country. We will have those tests available, FDA-approved tests, to get out there more broadly, locally. So those—that was as of last Friday.

And, as I said, Commissioner Hahn, working with the private sector, believes that there will be many, many more tests available——

Mr. KHANNA. Can we set a goal that we should be the number-one country in having more tests than any other country? I mean, it seems——

Mr. HARGAN. I believe the——

Mr. KHANNA [continuing]. absurd that we couldn't lead in that.

Mr. HARGAN. I believe, by Friday, we will see a substantial uptick in that.

In many cases, what we also have to make sure is that we have accurate testing, that we make sure that—and CDC work closely with FDA to make sure that our tests were accurate.

Mr. KHANNA. And is there a reason we are not using the WHO test, the World Health Organization that so many other countries are using?

Mr. HARGAN. Well, we often—WHO is often relied on by countries that don't otherwise have resources in this area.

Mr. KHANNA. Right.

Mr. HARGAN. So many times we, or countries in our—we will have our own tests for these particular——

Mr. KHANNA. But, I mean, in this case, I mean, my view is we should just get the tests out there. Can we explore if that is something we should do?

I mean, I agree, we should be building our own tests, but if we can test more people, why not use that?

Mr. HARGAN. Well, we can—I will definitely take that back to CDC.

Mr. KHANNA. Great.

Mr. HARGAN. Thank you.

Mr. KHANNA. The other issue is can we assure people that the testing and the treatment will be free for anything related to the coronavirus?

Mr. HARGAN. I think when we get—for example, with regard to vaccines, we are working—we will—our scientists have developed some of the intellectual property underlying the vaccines, and we will be negotiating with any private-sector entities——

Mr. KHANNA. What about—I just see time—and what about this—the testing for a coronavirus? If you want to get a test, you should have it free. If you want to get treated for coronavirus, that should be free.

Mr. HARGAN. I think any—if Congress intends to put that kind of—that into the supplemental, we will work with them——

Mr. KHANNA. Would you support something like that?

Mr. HARGAN. We will work with all the particularities of exactly how Congress wants to do that funding. I am—assume you all would have discussions amongst yourselves about how you would like to——

Mr. KHANNA. Do you think that may be a good idea?

Mr. HARGAN [continuing]. provide funding on that area.

I am not going to sort of double—second-guess Congress on how you decide to allocate resources, whether it is to testing vaccines, surveillance, personal protective equipment, therapeutics.

We have got a lot of proposals on there, state and local support for responses. So there are a lot of elements to go into that. So I think we look forward to working with you all——

Mr. KHANNA. My final question, just because of my time, I ran in, actually, at a coffee shop to Dr. Sanjay Gupta, and he raised an important point. He said that there are only 64 to 70,000 ventilators across the country, and that we may need more, especially as this is affecting the elderly. Has there been some concerted effort to make sure we are getting more ventilators in our hospitals and public facilities?

Mr. HARGAN. Yes, we have been talking extensively with the manufacturers of masks and ventilators to increase supply of them and other personal protective equipment.

Mr. KHANNA. If you could keep Congress apprised of what we are doing to get more ventilators across the country, that would be great.

Mr. HARGAN. Understood.

Mr. KHANNA. Thank you.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from Oklahoma, Mr. Hern, for five minutes.

Mr. HERN. Mr. Chairman, thank you. It is good to be here. I always find it interesting that we have these hearings talking about somebody else's budget, and we haven't done our own. I—by the end of next week I will be in seven different hearings across three different committees talking about the President's budget, and yet we have yet to create a budget.

These hearings often do—I just heard my colleagues say they start questioning the integrity of other agencies, as opposed to trying to find the underlying reason why we have not produced a budget. Maybe if we produced a budget, we could spend all this energy that we have been spending in Congress reconciling the differences between the President's budget and our budget, and having a real fight over ideology, as opposed to an ideology of having no values regarding a budget. So it is fascinating.

You know, the Speaker often talks about the President destroying the Constitution. Yet one of our fundamental constitutional duties is to produce a budget. First—it is the first clause of the enumerated powers, and yet we have not done it. There is no intention to do one, because that would show the true underlying integrity of the values of the Democrat Party.

And, you know, it is very frustrating. It is very frustrating for people to call my office—they know I am on the Budget Committee—and ask the question, "Why are the Democrats putting a budget on the floor?" (sic) We didn't do it last year. We did pass it out of this Committee last year, I will give the Chairman credit for that, but we didn't even pass it on the floor. And this year we are not even going to do that. So it is very troubling. And for my colleagues across the aisle to disregard that as a responsible—a constitutional duty of their office to be on this committee is just dumbfounding.

You know, right now the Medicare Trust Fund is going to be out of business in six years. We have got to get after real structural changes to that to understand how we are going to keep our ac-

countability and our responsibility to those who paid into that fund.

And quite frankly, the true word of "entitlement" comes if I give you money, which I have paid in my entire life, as everybody else in this room has, I am entitled to get that service back to me. And we are not going be able do that because we have raided those funds over the years. We haven't kept up with the pace of our aging population and the soaring costs of health care in America.

I could go on forever and ever talking about these fundamental failures in Congress. They are really good at blaming other people, because that sells well back in the district for their races that are coming up this year. But I want to ask you some questions about the underlying things that you can tell us about President Trump's position on America's health care.

Where is the President at on pre-existing conditions?

Mr. HARGAN. The President—it is a centerpiece of what we are doing, is making sure that Americans with pre-existing conditions are protected.

Mr. HERN. So he said that in his State of the Union. It has been said numerous, numerous times. The leader of the Republican Party has said it numerous times. You just said it again. I assure you that the left-wing media will not ever report that it was—it is going to be a centerpiece. They are going to still say it is not true.

Could you also help me understand how—just talk about what is going to be in that budget. What is it going to look like for Medicare, the prescription drug costs, changing premium deductibles, co-pays, or co-insurance?

Mr. HARGAN. Right. So, with regard to what we are doing on Medicare and Medicaid, what we are proposing is, in some cases, taking out payments that have been allocated to Medicare, historically, like graduate medical education and DSH funding, that really, we don't think, belongs in—being paid for by America's seniors. It really needs to be an item that is outside—not being paid for by the Medicare Trust Fund. That means that that trust fund is now going to be dedicated to the programs that people have paid into, into that trust fund, as you pointed out.

We are also trying to slow the rate of growth of the programs. That is not cutting the programs, but slowing the rate of growth. We think, between the reforms that we have got, we have got 25 years left in the trust fund with these reforms. We believe that these reforms, something like this, has to be enacted at some point to save these programs.

Mr. HERN. Can I stop you right there, just because of time?

Have the Democrats sent any proposal this year for just how we are going to save Medicare? It would be in their budget, right, how they are going to do that?

Mr. HARGAN. I have not—I am not aware of a——

Mr. HERN. OK, I just want to make sure we got that on the record.

Are there any things that are in the proposal this year that are the same as President Obama had in his proposals, as well?

Mr. HARGAN. We do propose—in terms of what President Obama said?

Mr. HERN. Mm-hmm.

Mr. HARGAN. Yes, we continue to sort of, as I say, keep forward Medicare, Medicaid, the regular parts of our budget that have gone on administration after administration.

Mr. HERN. I think the Medicare increase was 6 percent, or something. Is that——

Mr. HARGAN. Yes. And we are proposing—it is still a relatively—it is—we anticipate Americans' wage growth is about 3 percent per year. That is about—matching what we are proposing for Medicaid. And the Medicare proposal is higher than that.

Mr. HERN. OK. Mr. Chairman, thank you. I yield back.

Chairman YARMUTH. The gentleman's time is expired. And I now recognize the Acting Ranking Member for 10 minutes, the gentleman from Georgia, Mr. Woodall.

Mr. WOODALL. I appreciate the acting title, Mr. Chairman. I know Deputy Secretary Hargan is familiar with the acting title, and it conveys all the same responsibilities, just without any of the credit.

I wanted to talk a little bit about where Mr. Khanna left off, Mr. Hargan.

I think about the conflicting responsibilities you all have to actually be thinking ahead about ventilators, about masks, about not what is happening right now, but what is going to happen 12 months from now, 18 months from now.

And then you also have a committee of 435 on the House side that wants to know what is going on. We may not be thinking about what is going on 18 months from now, we are thinking about what our constituents called us about yesterday. And so we are asking you to do all of this planning that you are absolutely doing so well. And we are also putting additional reporting and attendance requirements in along the way.

I don't want you to have to throw anybody under the under the bus, but is that a manageable load?

We are in crisis right now. You all are responding to something that I have not seen that level of response to, and—in my lifetime. And it seems as if the demands that Congress is making of you are rising, instead of falling during that time.

Mr. HARGAN. Well, we have emergency response functions that are animated when these kind of things happen. We have been preparing, with Congress's resources, for the past two decades of giving money through the hospital preparedness program, through our prep money that is given by CDC to states and localities, and through exercises that go on every year between our preparedness and response people at HHS and their state and local partners. The most recent one was in August 2019 called Crimson Contagion that dealt with an outbreak of epidemic disease.

So there has both been money—over about two-thirds of a billion dollars—that is spent every year on CDC for—the money that is laid out for preparedness. So we have a strong public health infrastructure to deal with preparedness and response.

Now, in the case of this outbreak, as we would also anticipate, the Administration came forward last week, 10 days ago, with a supplemental. So we had asked for $2.5 billion. We understand that there is a possibility of Congress raising that number substantially above that.

As the President said, we are open to that. We are happy to receive whatever funds that Congress sees fit to allocate to us. We look forward to working on that or any authorities or resources that Congress sees fit to give us to deal with this particular issue.

Mr. WOODALL. Well, I appreciate that recognition.

Mr. Khanna asked whether or not you believed these tests should be free, and whether the treatment should be free. The Constitution doesn't give you the responsibility or even the opportunity to decide how money gets spent in this country. That responsibility lies specifically with us, here on the Budget Committee, but certainly across the 435 of us, collectively. And if there is going to be free health care in this country, it is going to be because Congress passes a law that makes that the case.

I would tell you I have been paying my health care premiums for the last 30 years and, thankfully, I have not had to rely on that health care infrastructure. I don't need you to provide me with free care. I want my insurance company to provide me with free care, because I have been paying them for that, just in case. I know there are going to be other families that need those dollars, and I think it would be a terrible waste to blanket the country with free benefits. Target those benefits to the families that need them the most. I know that is what you have to do every day, in terms of prioritizing.

It is hard to pass budgets. I have been on the Budget Committee since I came to Congress. And we have had to twist Republican arms every single year Republicans got a budget passed, because it is hard to put something out there to let somebody shoot at. I cannot tell you how much I value that that is a requirement that the law places on the Administration. And in an area as sensitive as yours, you all and the President stepped up to the task to make that happen.

I appreciate you standing up for the fact that reductions in the rate of growth are not cuts in benefits to folks. A Medicaid program—as you know, we have been working on a block grant for Medicaid in Congress for quite some time.

In so many states the only health insurance program in the state that doesn't dissuade people from attending the emergency room instead of their primary care physician is the Medicaid program. And to the extent that I am able to move a family out of the emergency room and into a relationship with a primary care physician, I am saving money for the taxpayer, no doubt, but I am not cutting benefits to that family, I am adding value to that family by moving them out of the ER, where care is sporadic, and into that relational care that a primary care physician can provide.

So I know it is an easy line of attack that you will hear again and again and again, and I thank you for—hopefully, if we say the truth often enough, every year there is an increase in spending—then we will have some breakthrough.

The Chairman knows what I know, which is if we don't turn the corner on federal spending, and federal revenues, and the inequality between the two, we are going to crowd out all the spending. Forget whether or not you want the CDC spending to go up or go down. It is going to get crowded out to zero, and there won't be anything you can do about it. I am anxious for us to take on some

of those challenges, and I appreciate your efforts, particularly in the Medicaid program, to do that.

But because we have talked so much about cuts, I want to talk about some of the some of the really great, great news. CDC is just south of me in Georgia, we are tremendously proud of what they do. It is not lost on me that, when they rescued Congress from the anthrax outbreak in—at the tail end of two decades ago, their spending rose dramatically after that.

[Laughter.]

Mr. WOODALL. Their campus became much more attractive after they after they rescued us. You don't realize who you need, often, until it is too late. And that continual investment that you talked about, year after year, of the Administration is meaningful to me.

But let's talk about the opioid program for a second. I know you made over $150 million in new resources available there. Is there something in particular that you were targeting those for?

Or—again, different communities have different needs. You want to make sure additional resources are available.

Mr. HARGAN. Yes. So, you know, this has been one of the signatures for this Administration, was the President's early recognition of the fact that the opioids crisis had to be dealt with in the United States.

It is an area where we have seen, last year, the very first downturn in 20 years in drug overdose deaths by, I think, over 4 percent. That is still far too high. But it does mean that the tremendous amount of support and resources and authorities that Congress has given us over the past few years are being put to good use.

We are finally starting to see some real effect in the United States, particularly in the hardest-hit communities, on rural inner-city communities that have been devastated by this. I mean we saw three years of lowered life expectancy for Americans, overall. Last—our—last year we finally saw an uptick for the first time in four years. But we have not seen a downturn in life expectancy. And the real change was the change in drug overdose deaths.

So we have seen success here in the state opioid response grants that are provided to states, to tribal areas that are really starting to affect what they can do, particularly the huge uptake in medication-assisted treatment that we have been working on. So we have seen an increase in people getting medication in Naloxone and other medications that are allowing them to get real treatment to survive the drug overdose deaths.

There is more to it than that. There are many elements of this, including how we treat pain, revising how opioids are prescribed, looking at surveillance, making sure that doctors know whether a patient is getting prescription drugs from many different sources, increasing the cooperation between different elements, between the us and the federal government, the states, the localities, social services on one side, and many elements that deal with people who are afflicted by opioids.

So we have got a long way to go. We are coming down from historic levels of drug overdose deaths, so we don't regard this as the end of the road at all, but really the beginning.

Mr. WOODALL. Well, that is something that 435 Members of Congress share in support of.

Another program like that—I think you are in your second year of the ending HIV initiative, not treat it, not survive it, end it with another big plus-up in funding.

Mr. HARGAN. Right.

Mr. WOODALL. Could you talk about that?

Mr. HARGAN. So we proposed a really large increase this year, hundreds of millions of dollars increase for the ending HIV epidemic. So we are in year two.

The first year was really spent on some intensive planning, on intensive preparation among the localities. We have targeted the highest number of—where the continuing infections are happening. Fifty-seven jurisdictions, we are going to be moving into those.

Eventually, because our public health experts think that we now have, technologically, through certain medications, the ability to suppress the virus, to prevent its transmission, that will eventually cause no more transmission. That means no more new infections with HIV. We believe, technologically, we can get there.

Congress did great, gave us great resources last year. I think we achieved what we wanted to achieve last year in terms of, like, planning and preparation for what we are going to do, and starting the work.

I think now we are looking at year two, we are looking at a substantial increase in that amount, because now we are going to be moving into implementation of the plan. But hopefully, by 2030 we are going to see the real—starting the real end of this epidemic.

Mr. WOODALL. Mr. Chairman, it would make your job easier if we had more of an opportunity to celebrate those kinds of shared successes.

When you think about budgets, you think about everything we disagree about. And we could have gone on and on. We could go on to maternal mortality rates, and a pilot project that they are now expanding to 50 states, things that you and I support, that all of our colleagues support. And sadly, most of the microphone time gets spent on those things that divide us, instead of that unite us.

So thank you for having this hearing, an opportunity to talk about those things that bring us all together.

Thank you for your service, Deputy Secretary.

Mr. HARGAN. Thank you, Congressman.

Chairman YARMUTH. The gentleman's time has expired. I now yield myself 10 minutes.

Once again, Deputy Secretary, thank you for being here. Thank you for your responses, and I thank all my colleagues for their contributions.

I want to clarify one thing for the record that Mr. Roy mentioned, because he mentioned that the President's budget—this has nothing to do with your specific Department, but the President's budget was in—came to balance. Yes, it does in the 15th year. He had to go 15 years to get it to balance. In the—and make growth assumptions of 3 percent a year, which are far in excess of what virtually anyone else projects. And in the course of doing that, it runs deficits of over $1 trillion for the rest of this decade.

So it is a little bit disingenuous, I think, to say that this balances—the President balances the budget .

But I want to turn to the issue of what is a cut. It has gotten a lot of attention today. It got attention during the discussion we had with the director of OMB a few weeks ago.

And I have to smile a little bit to myself when I hear this discussion, because—and this is no—not directed at anybody on this side of the room, because nobody was here in 2010, when we discussed the—when we drafted and passed the Affordable Care Act. But I remember very vividly in the fall of 2010, leading up to the campaign, when Republican after Republican, in their campaigns, talked about how Democrats were cutting $700 billion out of Medicare, $700 billion. I can't imagine how many millions of dollars were spent making that attack on Democratic—congressional Democrats in 2010. And we said the same thing. We said, "We are not making cuts, we are reducing payments to providers."

But on the other hand, we added services, free checkups every year, a variety of other additional services that seniors have not gotten. And we raised revenue. We imposed a provider tax. So, while we cut providers in one area, we said, including DME—that has come up today—3.8 percent tax. Everybody ought to contribute to the cost of this program.

So when I see—we can argue whether lower costs, lowered rates of growth are cuts or not, we know that roughly 1.5 million people, additional people, on net, join the Medicare beneficiary ranks every year. So there—it is not just the cost of the care, the general inflation of the care going up, it is also the population is growing over the next 12 years. It grows by 18 million people, projected.

So, yes, obviously, there is a—again, we can run the numbers on that, and we can fight over whether lowered growth amounts to a cut or not. But again, 10 years ago there was a lot of hand-wringing over that same issue.

And so I will ask you, Mr. Hargan, does the President propose any additional services to Medicare in the budget?

Mr. HARGAN. So there are increases. For example, the telehealth services that we talked about. So with regard to rural providers, we—so we think that there are areas where expansion of these things is possible, for example. And also, as I mentioned about colonoscopies, so in that area, so that people aren't sort of surprised by having a polyp removed and then getting a bill that will sort of—while they are in the middle of it, doing the best practice, the doctor does it and then a bill shows up at the end. So we are proposing to reform that area, as well.

So there are areas where we are proposing, where we think there are limited areas where we can provide extra benefit.

Chairman YARMUTH. Those are services, generally speaking, across the entire health care spectrum, not necessarily targeted to Medicare beneficiaries. Right?

Mr. HARGAN. And these are areas, though, where, if we eliminate co-insurance, for example, for colonoscopies, that is definitely—in Medicare we are proposing extending coverage of immunosuppressive drugs with regard to transplants.

So now, whether that results in a—that may result in a savings over time, because, if they are applied, you result in potentially

fewer hospitalizations and increased care later. But it does—it is going to be a coverage, extra coverage for something.

So there are areas where we have proposed increases in coverage, compared to what we have now.

Chairman YARMUTH. Does the President's budget propose any increased revenues to the Medicare program?

Mr. HARGAN. Well, I think that we would look to the revenue side, rather than the budget side for this, in terms of increased revenues.

Chairman YARMUTH. So let me segue into the conversation you had about pre-existing conditions, because this also intrigues me. I have challenged my colleagues on many occasions to tell me exactly how you protect pre-existing conditions without either the Affordable Care Act or Medicare or Medicaid. How can you preserve pre-existing conditions in the private insurance market without—well, I just ask you, how can you do it differently than the Affordable Care Act attempted to do it?

Mr. HARGAN. I think Congress had put forward a number of proposals over the past few years dealing with pre-existing conditions.

Chairman YARMUTH. Congress has put forth proposals to guarantee issue. Congress, to my knowledge, has never put forth a proposal where you have guaranteed issue, and also affordability concerns.

In other words, you can force insurance companies to sell anybody a policy. But if you are not going to regulate the price, then you haven't really protected them. Is that correct?

Mr. HARGAN. Well, I mean, the—as you know, the existing law, ACA, produces some of those——

Chairman YARMUTH. Yes, exactly. Outside the ACA. And so I—again, it is just perplexing to me—and this is where we were back in the repeal-and-replace debate, which we went through for eight years. It was, OK, how are you going to replace it? And there was never a proposal.

And the reason there was never a proposal was because the only way to replace it with anything that makes sense is universal health care, or Medicare for All, or some version of it. And my colleagues knew that. And that is why I am sure they were absolutely relieved when John McCain put thumbs down on the Senate floor, because they would have had to come up with a proposal, and they didn't have a way to do that.

But I want to go also now—and this is related—on the question of prescription drug prices. You said, and I appreciate it very much, that you stand willing to work with Congress to come up with a solution.

So the House of Representatives, under a Democratic majority, passed a bill, H.R. 3. The Administration doesn't support it, Republicans in the Senate don't like it because they refuse to take it up. So what is the responsibility, if you say you are willing to work with us?

We put forth a proposal. Don't you think either the Administration or Republicans in the Senate have an obligation to work with us or, if they don't like our proposal, to come up with an alternative, or some amendment of ours, some modification of H.R. 3 to deal with that?

Mr. HARGAN. Well——

Chairman YARMUTH. It is not—I mean I appreciate your willingness to work with us, but don't you have a responsibility to advance some ideas of your own?

Mr. HARGAN. Well, I would say that we have articulated at least four principles that I think would be broadly acceptable, which is that lowering list prices, lowering patient out-of-pocket costs, improving competition, and creating better conditions for negotiation. Those are the priorities, high level, that we have talked about in terms of drug pricing, which we think would fix it.

I mean we have seen a number of bills that have been proposed on both sides, in the House and in the Senate. Now the question of reconciling the congressional bills, I think, we would look to the Congress to move those forward. And we look forward to working with you, providing whatever technical assistance or advice that we can as you all work through preparing, as we say, a bipartisan, bicameral solution.

We do have, as I say, a lot of—a deep bank of experts within HHS who we would make available to anyone working on bills. And we—as I say, we have an articulated set of principles, and the President is 100 percent behind this goal. And we are, at HHS. We know it is the articulated concern for Americans to bring down drug costs. And so, if we can do that, I think that is going to be good for everyone.

Chairman YARMUTH. Yes. You know, I think everybody here would agree with the principles that you put forward. Those are kind of—OK, that is motherhood and apple pie. We could—we can accept those.

But if the Senate is not going to act, and the problem exists, and the American people are paying the price every day, don't you think that the Administration—not necessarily HHS, but at least the White House—has an obligation to lead in this area if—we have tried to do our part in the House, the Senate has refused to act. I just contend that the White House and the Administration have an obligation to lead on this issue, and not just say, "We would be willing to work with you," because that does not move the ball forward an inch.

And my time is about to expire. I just have one quick question on coronavirus. Is there modeling done that indicate—would indicate the range of possibilities for transmission of this disease?

And if so, why shouldn't the American people have the range of possibilities?

Mr. HARGAN. Well——

Chairman YARMUTH. Have you modeled yet what the kind of extreme possibilities might be?

Mr. HARGAN. So I know that there have—there are available—there are disease spreading models that have been out in public, frankly, for dealing with infectious disease. And a lot of those have been exercised in the past to actually—in—you know, in accordance with some of the preparedness work that has been done in the past. So I would be happy to share that with you, and talk through if—as—talk through with people exactly how those kind of things are arrived at.

Chairman YARMUTH. I appreciate that. And I know there is the potential for alarming the public unnecessarily, and you don't want to do that.

But again, I think the public does have, I think, the right to understand how little this could spread, or how much it could spread. But——

Mr. HARGAN. Exactly.

Chairman YARMUTH. But anyway, I appreciate your——

Mr. HARGAN. Yes, sure.

Chairman YARMUTH [continuing]. cooperation.

Mr. HARGAN. Thank you.

Chairman YARMUTH. We will work with you on that.

Mr. HARGAN. Thank you.

Chairman YARMUTH. And once again, I thank you for your appearance here today, and all of your responses.

And with—unless there is any further business, I—this hearing is adjourned.

[Whereupon, at 12:11 p.m., the Committee was adjourned.]

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CONGRESSWOMAN SHEILA JACKSON LEE OF TEXAS

STATEMENT
HEARING:
"U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2021 BUDGET"

COMMITTEE ON THE BUDGET
210 CANNON
MARCH 4, 2020
10:00 A.M.

- Thank you Chairman Yarmuth and Ranking Member Womack for convening this hearing on the President's proposed FY2021 budget for the U.S. Department of Health and Human Services, and related agencies.

- Let me welcome our witness, HHS Deputy Secretary Eric Hargan.

- In short, Mr. Chairman, this phony numbers and fuzzy math HHS budget is Act III of the immorality play we predicted that the President would write.

- Act I was the cutting of taxes for the rich; Act II was the inevitable exploding of the deficit we predicted would result and our Republican friends denied would ever happen.

- The President's proposed budget projects FY2021 revenues of $3.7 trillion and outlays of $4.829 trillion, leaving a deficit of $1.101 trillion.

- Which brings us to Act III, in which Republicans claim to have newly rediscovered their horror over the deficits created by their fiscal irresponsibility and insist that the mess they created be cleaned up by slashing investments in the health and services programs relied upon by the 90-95 percent of Americans who were made worse off by the GOP TaxScam.

- The President's 2021 budget jeopardizes the health care security of millions of Americans and their families. Instead of investing in protecting public health and improving the health care programs millions of Americans rely on, the budget calls for massive funding cuts and extreme policy changes.

- Overall, the budget calls for a $9.5 billion cut to HHS's discretionary budget in 2021 and a $1.6 trillion cut over 10 years from mandatory health care spending, including more than $900 billion in cuts to Medicaid, a half a trillion-dollar cut to Medicare, and more than $200 billion in cuts to other health programs.

- Taken together, the health and human services proposals included in this budget paint a bleak picture of the President's vision for the future of health care in America and the federal government's responsibility to help families struggling to get by.

- Mr. Chairman, Coronavirus has been declared a public health emergency in the U.S. and internationally, with over 88,000 cases of this fast-moving virus reported as of March 2.

- Coronavirus is in the headlines right now, but every year tens of thousands of Americans die from seasonal influenza and other infectious diseases.

- Strong investments in our nation's public health infrastructure are crucial but the Administration proposal originally cut CDC's discretionary budget by nearly one-fifth and its overall budget by 9 percent, or $700 million.

- Medicaid covers the care of 6 in 10 nursing home residents, many of whom are older or have chronic medical conditions, putting them at higher risk for severe illness but the $900 billion in cuts to Medicaid originally proposed by the President negatively affect the ability of nursing home residents enrolled in Medicaid to access treatment for coronavirus and other infectious diseases.

- The National Institute of Allergy and Infectious Disease (NIAID) supports research to better understand, treat, and prevent infectious, immunologic, and allergic disease but in the midst of the current Coronavirus crisis, the President's proposal cuts NIAID by $430 million.

- This budget for HHS makes it very clear that the President's priorities are not with the "forgotten Americans" that he claims to represent.

- How else could he justify the following draconian cuts to lifesaving and life-changing programs.

- The discretionary budget for HHS is cut by 12 percent - $9.5 billion.

- Medicaid is cut by $900 million over ten years, breaking one of the President's signal campaign promises, and this budget calls for the complete repeal of Medicaid expansion, converting the program into a block grant or per-capita cap, and requiring all states to implement so-called work requirements.

- Breaking another key campaign pledge, the President's budget makes several changes to Medicare by shifting costs onto hospitals, post-acute care providers, and some beneficiaries, reducing federal spending by more than $400 billion.

- Breaking yet another of his campaign promises, that "everybody's going to be taken care of" – the President's budget replaces the Affordable Care Act (ACA) not with "something terrific" but with a state block grant that grows with the rate of inflation, meaning it would decline over time relative to need and leave millions of Americans without meaningful health insurance.

- This budget makes life harder, much harder, for people living with HIV/AIDS by cutting funding for the National Institute of Allergy and Infectious Diseases, which is responsible for most of the HIV/AIDS research at NIH, by 8 percent.

- The President's budget is short-sighted in another critical respect; by slashing funding for the Centers for Disease Control and Prevention by 9%, or$700 million, the budget puts the nation at risk because CDC protects the nation's health through population health surveillance, research, and work with partners across the globe to identify health, safety, and security threats.

- Almost 85 percent of CDC's domestic funding goes to state and local public health departments so these cuts would have serious impacts on public health agencies in every state.

Budget Slashes Programs Supporting Children and Families

- Mr. Chairman, because Temporary Assistance for Needy Families (TANF) block grant funding has remained flat at approximately $17 billion each year since 1996, the purchasing power of TANF benefits has eroded substantially in most states.

- Notwithstanding that TANF is severely underfunded, this cruel budget goes after the most vulnerable Americans by cutting 10% from the TANF base program.

- Additionally, the budget cuts $6 billion over ten years by eliminating the TANF contingency fund, preventing the government from ensuring struggling families can access the basic supports they need to get by during future economic downturns.

- The budget completely eliminates the Social Services Block Grant (SSBG), costing states $16.6 billion in funding over 10 years (roughly $1.7 billion per year).

- States use this funding to decide how best to improve and complement services like foster care, child protective services, day care, case management, and other services that protect vulnerable children and adults; in 2016, as many as 26 million Americans across all 50 states received services supported in whole or in part by SSBG.

- Head Start is level funded at $10.063 billion, which will only serve 857,000 children, a decrease from the estimated 870,000 slots funded in 2020 and enough to fund less than 31 percent of children aged 3–5 eligible to participate in a head start program.

- Mr. Chairman, it is cruel and heartless to eliminate funding, as this budget does, for Low-Income Home Energy Assistance Program (LIHEAP).

- Cutting this $3.7 billion program puts millions of families at risk when extreme temperatures hit, both in the summer and in the winter.

- This budget completely eliminates CSBG, a block grant program that allows states, territories, and tribes to reduce poverty by focusing on effective ways to address employment, education, housing, nutrition, and health.

- CSBG grants served roughly 17 million individuals from 7.3 million families and were funded at $725 million last year to meet our shared goals of lessening poverty and improving outcomes.

- There has not been a single mention of the burden placed on families as a result of the soaring prices for prescription drugs in this country.

- For the 1.25 million Americans living with type 1 diabetes, as well as some with type 2 diabetes, insulin is as crucial to living as air.

- The skyrocketing cost of insulin has become a crisis in the United States.

- Americans everyday are struggling to pay the price of their required medicine, deciding between paying rent or covering a health bill, and skimping or rationing the dose(s) of their medicine to make ends meet at the end of the month.

- Many people with diabetes in the United States are forced to take extreme measures to stay alive while they wait for lower prices.

- Every year, there are significant increases to the price of prescription drugs as seen from the past decade when the cost of insulin shot up and roughly tripled from just under $100 in 2009 to almost $300 today.

- It is in response to this growing concern that House Democrats introduced, and I have cosponsored, H.R. 3, the *"Elijah E. Cummings Lower Drug Costs Now Act,"* which provides numerous mechanisms for reducing prescription drug prices, but most notably, it would allow the federal government to directly negotiate the prices it will pay for up to 250 drugs every year.

- H.R. 3 responds to the outrageous prices of prescription drugs and the growing nationwide need of individuals who need their medicine but cannot afford it.

- Rather than passing H.R. 3 and providing relief to the millions of Americans who daily have to choose between medicine and food, or monthly between taking full doses of their medicine or paying their rent, this life-saving legislation in Senate Majority Leader Mitch McConnell's legislative 'graveyard.'

- Mr. Chairman, to cut this budget in general seems shortsighted; to cut it at a time when fears of a coronavirus pandemic grow every day seems downright wrong.

- Mr. Chairman, this budget would undermine the very programs relied upon by poor, working, and middle-class families and our nation's most vulnerable citizens: children, senior, the disabled, and the homeless.

- There is much wisdom in the adage that "the President proposes, the Congress disposes."

- Mr. Chairman, this budget should be declared DOA and Congress should get to work on fashioning a budget that reflects the priorities and addresses the real challenges facing the American people.

- Thank you; I yield the remainder of my time.

Questions for the Record for HHS Deputy Secretary Eric Hargan
Submitted by Mr. Yarmuth following the Budget Committee hearing on March 4, 2020

1. In your written testimony, you noted that by February 28, 2020, HHS is required to post its guidance documents to a searchable database pursuant to an Executive Order on "Promoting the Rule of Law through Improved Agency Guidance Documents." You also explained that guidance documents not posted to the website are, quote, "deemed rescinded." Guidance documents can be very important, ranging from statements of the agency's enforcement practices on which people rely, to formulae for calculating payments to states. And, I understand from OMB's guidance for that Executive Order that agencies have the chance until June 27, 2020, to reinstate any guidance documents that it neglects to post. I assume that HHS is keeping track of which guidance documents it is rescinding by declining to post them to its website.

   Can you share that list of now rescinded guidance documents so the committee and perhaps the public might assess whether any should be reinstated? What was your process for deciding which guidance documents to include on the website and which to exclude, and thereby, rescind?

2. The budget's mandatory work requirement proposal is expected to save Medicaid $152 billion over 10 years. This is $22 billion more than the score of last year's proposal, which was expected to save $130 billion over 10 years. What accounts for the increased savings associated with this proposal? Has HHS estimated the number of people who would lose Medicaid coverage if this proposal were enacted?

3. Does the Medicaid baseline assume implementation of the guidance announced by CMS Administrator Seema Verma on January 30, 2020 to encourage states to move their Medicaid programs toward a block-grant structure? If so, how many states does CMS estimate will participate in the so-called "Healthy Adult Opportunity" demonstration? Does the inclusion of this demonstration increase or decrease projected Medicaid outlays in the baseline? By how much (per fiscal year and over the 2021-2030 period)?

4. Does the Medicaid baseline assume implementation of the proposed Medicaid Fiscal Accountability Regulation (MFAR)? If so, does the inclusion of this proposed regulation increase or decrease projected Medicaid outlays in the baseline? By how much (per fiscal year and over the 2021-2030 period)?

5. Please disaggregate the "Medicaid Administrative Actions and Guidance" line (row 141 of the Excel file) in Table 21-4, Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline. For each administrative action, guidance, or regulation, please provide the budgetary effect by fiscal year and over the 2021-2030 period.

6. The Office of Management and Budget is considering a number of changes in the measurement of poverty, such as shrinking the inflation adjustment, counting the value of health insurance, or giving greater weight to consumer items in the household. These changes would be expected to

reduce the estimate of how many people are poor, but would ignore research showing that people with incomes well above the current poverty thresholds report significant hardships in paying for rent, food, heat, and child care. Eligibility for many HHS programs is determined based on HHS poverty guidelines. Are you concerned that these changes are likely to define many beneficiaries of health care, child care, and other social services as ineligible despite not being able to afford the help they need? How many individuals would lose eligibility to HHS resources under the Administration's proposed poverty changes? Of that estimate, how many children are impacted? How would the proposed changes make it harder for state and local governments to respond to the next recession and help vulnerable families? Has HHS expressed such concerns to OMB?

Questions for the Record
Congressman Chris Stewart (UT-02)
Department of Health and Human Services Fiscal Year 2021 Budget
March 4, 2020

There are several companies in my district, such as Navigen and Co-Diagnostics, that are working on finding public health solutions to the Covid-19 outbreak. What is the agency doing to leverage public private partnerships to find solutions to the outbreak? How do companies like Navigen and Co-Diagnostics, with novel ideas, work with the federal government on developing vaccines, diagnostic tests, other drugs to protect the public from Covid-19?

Deputy Secretary Hargan FY2021 Budget Hearing
House Budget Committee
Questions for the Record
March 4, 2020

Chairman Yarmuth

1. In your written testimony, you noted that by February 28, 2020, HHS is required to post its guidance documents to a searchable database pursuant to an Executive Order on "Promoting the Rule of Law through Improved Agency Guidance Documents." You also explained that guidance documents not posted to the website are, quote, "deemed rescinded." Guidance documents can be very important, ranging from statements of the agency's enforcement practices on which people rely, to formulae for calculating payments to states. And, I understand from OMB's guidance for that Executive Order that agencies have the chance until June 27, 2020, to reinstate any guidance documents that it neglects to post. I assume that HHS is keeping track of which guidance documents it is rescinding by declining to post them to its website.

   Can you share that list of now rescinded guidance documents so the committee and perhaps the public might assess whether any should be reinstated? What was your process for deciding which guidance documents to include on the website and which to exclude, and thereby, rescind?

   Response: In accordance with Executive Order 13891, the Department reviewed its current guidance portfolio. The review included identifying guidance documents to remain active. HHS Divisions were able to identify over 25,000 documents that should remain active, and these documents have now been compiled into an online database that can be found at: www.hhs.gov/guidance.

   Executive Order 13891 helped the Department centralize its guidance documents by creating a new HHS-wide approval process and searchable database. Prior to the Executive Order, the Department faced challenges tracking guidance documents not considered significant (as defined by EO 12866) by OMB. HHS is now better positioned to have awareness of—and to identify—rescinded guidance documents, now that a searchable database has been created and a process has been implemented to add new items. As part of the Department's implementation efforts, divisions were asked to identify guidance that was still relevant and should remain active. As our work progresses, the Department's leadership will encourage divisions to consider feedback from stakeholders and the public about guidance that does not appear in the database, but may still be considered relevant. The Department is committed to fully complying with the Executive Order.

   Factors that HHS divisions considered when deciding to not include a guidance document in the portal were: (1) whether the guidance has been superseded by more recent guidance on the same topic; (2) whether the guidance no longer reflects current agency policies or practices, or is otherwise obsolete; and (3) whether the division has received a determination from our Executive Secretariat or General Counsel that the document does not meet the definition of guidance as outlined in EO 13891.

2. The budget's mandatory work requirement proposal is expected to save Medicaid $152 billion over 10 years. This is $22 billion more than the score of last year's proposal, which was expected to save $130 billion over 10 years. What accounts for the increased savings associated with this proposal? Has HHS estimated the number of people who would lose Medicaid coverage if this proposal were enacted?

   Response: The President's FY 2021 Budget includes a proposal to require states to implement Medicaid community engagement requirements for certain working age able-bodied adults. This proposal would result in an estimated $152.4 billion savings over 10 years (FY 2021- FY 2030), an increase of approximately $22 billion over the estimate in the President's FY 2020 Budget. This increase in savings is driven by the use of updated enrollment estimates for the FY 2021 Budget.

3. Does the Medicaid baseline assume implementation of the guidance announced by CMS Administrator Seema Verma on January 30, 2020 to encourage states to move their Medicaid programs toward a block-grant structure? If so, how many states does CMS estimate will participate in the so-called "Healthy Adult Opportunity" demonstration? Does the inclusion of this demonstration increase or decrease projected Medicaid outlays in the baseline? By how much (per fiscal year and over the 2021-2030 period)?

   Response: At this time, no, the baseline does not assume any implementation of Healthy Adult Opportunity demonstrations.

   The Healthy Adult Opportunity (HAO) initiative is a voluntary opportunity designed for states to use demonstration authority under section 1115(a)(2) of the Social Security Act to have increased flexibility in meeting the needs of their adult beneficiaries who are under age 65, qualify for Medicaid on a basis other than disability or need for long-term care services and supports, are not covered in the state plan, and for whom state Medicaid coverage is optional. All other Medicaid populations, especially the most vulnerable, will continue to be eligible through the state plan and other existing program authorities.

   The HAO initiative offers greater flexibility to states to provide cost-effective coverage for eligible non-disabled adults, but does not impact the majority of Medicaid beneficiaries. The HAO initiative promotes expanding coverage beyond existing baselines, through the furnishing of medical assistance to a targeted adult population in a manner that also promotes the sustainability of the program for current and future beneficiaries. Similar to other section 1115 demonstrations, the HAO initiative provides states with flexibility, beyond state plan and other existing program authorities, to design innovative health coverage programs tailored to the unique needs of their adult beneficiaries.

   The financing structure for the HAO initiative is similar to that of any section 1115 demonstration, and all section 1115 demonstrations are required to be budget neutral, which means that the proposed demonstration cannot be projected to cost the federal government more than what it would have spent on the state's Medicaid program absent the demonstration.

   While there are a number of states who are working through proposals that would be

considered under this demonstration authority, CMS has not currently approved any state's application for an 1115 demonstration under the HAO initiative.

4. Does the Medicaid baseline assume implementation of the proposed Medicaid Fiscal Accountability Regulation (MFAR)? If so, does the inclusion of this proposed regulation increase or decrease projected Medicaid outlays in the baseline? By how much (per fiscal year and over the 2021-2030 period)?

   Response: The proposed Medicaid Fiscal Accountability Regulation (MFAR), CMS-2393-P, was published in the November 18, 2019, issue of the *Federal Register*, with a 60-day comment period that closed on January 17, 2020, which was subsequently extended by fifteen days and closed on February 1, 2020. During this time, CMS also conducted numerous calls with states and stakeholders to receive substantive feedback to help understand the potential impact of the proposed rule.

   The proposed rule was designed to increase transparency in Medicaid financing and ensure that taxpayer resources support the healthcare needs of beneficiaries. The regulation was not projected to change Medicaid spending in the baseline.

5. Please disaggregate the "Medicaid Administrative Actions and Guidance" line (row 141 of the Excel file) in Table 21-4, Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline. For each administrative action, guidance, or regulation, please provide the budgetary effect by fiscal year and over the 2021-2030 period.

   Response: Please see the table below for the budgetary effect by fiscal year for the line item "Medicaid Administrative Actions and Guidance" in Table 21-4, Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline.

Table 21-4. IMPACT OF REGULATIONS, EXPIRING AUTHORIZATIONS, AND OTHER ASSUMPTIONS IN THE BASELINE
(Outlays or revenues in millions of dollars)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
(Medicaid) Administrative Actions and Guidance											
(Medicaid) Administrative Actions	**-55**	**-725**	**-1,415**	**-2,392**	**-2,833**	**-3,255**	**-3,616**	**-3,978**	**-3,212**	**-3,313**	**-3413**

6. The Office of Management and Budget is considering a number of changes in the measurement of poverty, such as shrinking the inflation adjustment, counting the value of health insurance, or giving greater weight to consumer items in the household. These changes would be expected to reduce the estimate of how many people are poor, but would ignore research showing that people with incomes well above the current poverty thresholds report significant hardships in paying for rent, food, heat, and child care. Eligibility for many HHS programs is determined based on HHS poverty guidelines. Are you concerned that these changes are likely to define many beneficiaries of health care, child care, and other social

services as ineligible despite not being able to afford the help they need? How many individuals would lose eligibility to HHS resources under the Administration's proposed poverty changes? Of that estimate, how many children are impacted? How would the proposed changes make it harder for state and local governments to respond to the next recession and help vulnerable families? Has HHS expressed such concerns to OMB?

Response: On May 7, 2019 the Office of Management and Budget published*Request for Comment on the Consumer Inflation Measures Produced by Federal Statistical Agencies Federal Register Notice*, 84 Fed. Reg. 19961 (May 7, 2019), indicating they will consider updating the specific inflation measure used to adjust the official poverty measure. The Office of Management and Budget has not published anything further on whether they are instituting any change in how the Census Bureau updates the official poverty measure and if so, whether any change would be based on lower, similar, or higher inflation adjustments compared to the current inflation adjustment used. HHS issues annual poverty guidelines consistent with statutory language from the Community Services Block Grant Act [42 U.S.C. 9902(2)]. These guidelines incorporate the previous year's poverty thresholds and are updated for inflation using the Consumer Price Index for All Urban Consumers. Without further information from the Office of Management and Budget, it is unclear what effect an instituted change in inflation adjustment for the official poverty measure may have on the poverty guidelines. We would refer you to the Office of Management and Budget if you have questions about the Federal Register Notice and the status of any potential changes to the inflation adjustment of the official poverty measure.

Rep. Chris Stewart

1. There are several companies in my district, such as Navigen and Co-Diagnostics, that are working on finding public health solutions to the Covid-19 outbreak. What is the agency doing to leverage public private partnerships to find solutions to the outbreak? How do companies like Navigen and Co-Diagnostics, with novel ideas, work with the federal government on developing vaccines, diagnostic tests, other drugs to protect the public from Covid-19?

   Response: Within HHS, ASPR/BARDA's long standing expertise in accelerating the advanced research and development of candidate diagnostics, therapeutics and vaccines through to FDA approval, licensures, or clearance, is unmatched across the government and underscores the overall capabilities that we have brought to bear on COVID-19. ASPR/BARDA oversees and manages the development and acquisition of Medical Countermeasures (MCMs), working with industry partners to facilitate the transition of promising MCM candidates from early research through advanced development to potential approval, licensure, or clearance. Since 2007, 55 BARDA-supported products have achieved regulatory approval, licensure, or clearance.

   Regarding COVID-19, BARDA has three pathways industry can take to form a partnership with BARDA.

   - To enable a rapid response to the COVID-19 pandemic BARDA has repurposed the existing TechWatch program to focus on COVID-19 MCMs. These CoronaWatch

submissions and meetings aim to give innovators and innovative companies a government-wide platform to discuss their ideas with U.S. government experts, and seek partnership opportunities with a wide range of potential federal partners. To date BARDA has supported over 3,600 of these meetings.

- To spur innovation, BARDA has issued its business-friendly, streamlined Easy Broad Agency Announcement (EZ-BAA) to support a number of new medical countermeasures to fight the COVID-19 pandemic.
- BARDA is investing in an array of medical countermeasures to diagnose, treat, or protect against the 2019 novel coronavirus under the BARDA Broad Agency Announcement (BAA-18-100-SOL-00003).

Companies can gain additional information about all of these approaches and about BARDA's ongoing efforts, such as the 94 COVID-19 partnerships, 29 supported products, and 13 EUAs for COVID-19 diagnostic tests, by visiting medicalcountermeasures.gov.