United States Senate Committee on Finance
March 14, 2025
Hearing to Consider the Nomination of Mehmet Oz, of Pennsylvania, to be Administrator of the Centers for Medicare and Medicaid Services, vice Chiquita Brooks-LaSure, resigned

Questions for the Record submitted to Dr. Mehmet Oz from Senator Cornyn.

Question 1:
For years, the Texas congressional delegation has raised concerns with efforts by CMS to restrict the ways states can choose to finance their share of the Medicaid program. CMS continues to challenge the legality of financing methods that are essential to Medicaid programs across the country and were previously approved by the agency.

Last year, the Biden Administration finalized a rule that alters CMS's interpretation of federal provider tax law on what is a permissible financing arrangement of the nonfederal share in Medicaid that goes far beyond the plain language of the statute. This gives CMS authority to withhold, condition, or retroactively deny approvals of state directed payments (SDPs) based on nonfederal share financing arrangements that are lawful and previously approved. The rule also mandates that appeals on any denials go through the Departmental Appeals Board or Office of Hearings and Inquiries. This would create excessive delays in resolving denials. These policy changes will harm Texas's ability to help the most vulnerable Texans.

- Will you commit to repealing these new and unlawful financing provisions and the decision to route all appeals of SDP denials to the Departmental Appeals Board or Office of Hearings and Inquiries?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

Question 2:
In 2023, the Biden Administration initiated a Review Choice Demonstration for Inpatient Rehabilitation hospitals and units in Alabama, which has now expanded to Pennsylvania and is in line to expand next to Texas, California, and eventually to 17 states and Washington, DC. This demonstration allows Medicare contractors broad discretion to make medical necessity decisions for every Fee-for-Service beneficiary that requires intensive rehabilitation care, frequently overruling the judgment of rehabilitation physicians who treat patients on a day-to-day basis. Only in the last few weeks has the agency begun to offer even broad metrics on the program's performance. The initial data from CMS shows that hospitals are consistently seeing more than 90% of their claims affirmed, but hospitals continue to report that the program is highly burdensome and threatens access to care for some Medicare patients.

- Given the Trump Administration's commitment to transparency and accountability in health care programs, will you commit to halting expansion of this program until there is

full transparency and an assessment of whether this is an appropriate use of government resources?

Response: I want to make sure that CMS is aggressive in modernizing the tools it uses to reduce fraud, waste, and abuse for Medicare inpatient rehabilitation facility services. If confirmed, I look forward to reviewing this demonstration to ensure that it is meeting that goal.

Question 3:
Countless patients continue to face gaps in access to care. This is especially true for mental health services. Far too many frontline providers face rising financial strain and paperwork burdens. Many patients still face high out-of-pocket costs or long travel times. These barriers to care are especially burdensome for rural Americans.

The Collaborative Care Model is one proven solution to many of these challenges. This model leverages a team-based approach to strengthen quality and coordination by integrating primary and behavioral health care. It can also drive down costs and improve patient outcomes. But startup costs and technical hurdles have limited uptake of this initiative. Senator Cortez Masto and I have reintroduced the COMPLETE Care Act. This legislation would assist providers in implementing this approach through both targeted financial support and technical assistance.

- Will you ensure CMS provides all requested TA to providers, should Congress pass this legislation?

Response: Yes.

Question 4:
I am concerned for U.S. precision medicine companies that have already navigated regulatory hurdles at FDA and then encounter delays as CMS works to update coverage decisions, so Medicare beneficiaries can gain access to their technologies. We need your help to ensure transparency in the coverage process and to prevent unnecessary delays in access to these potentially life-saving tools for the American people.

- Will you ensure transparency in the coverage process and be responsive to requests from members of this committee when our offices have questions about coverage decisions and updates?

Response: If confirmed, I commit to working with Congress as we work to streamline the regulatory process to improve the coverage pathway for new and innovative devices.

Question for the Record submitted to Mehmet Oz from Senator Daines.

Question 1: We currently have a Chief Dental Officer within CMS to help ensure that oral health is appropriately prioritized in policy decisions. Given the importance of oral health in overall health outcomes, do you support solidifying the CDO role as a permanent position within

CMS leadership? What steps would you take to ensure this position continues to play an integral role in advancing CMS's mission and addressing oral health needs?

Response: Oral health is an important aspect of overall health particularly as it relates to chronic conditions. If confirmed, I look forward to working with you on this issue.

Questions for the Record submitted to Mehmet Oz from Senator Hassan

Question 1: Surprise Medical Billing

- For years it was common for patients to receive huge surprise medical bills, where patients may have done everything right at the doctor's office or hospital, but still found themselves stuck with thousands of dollars in surprise bills.
- I worked with Senator Cassidy to pass the No Surprises Act into law in 2020.
- This law has prevented at least 10 million Americans from receiving surprise medical bills so far, thanks to the staff at CMS who enforce it.
- President Trump signed this bill into law in 2020 – and yet, his Administration has fired 15 percent of the workers in the office that protects Americans from surprise medical bills.
- If confirmed, will you commit to reinstating the CMS staff members who were working to enforce the No Surprises Act?

Response: I have not been involved in any staffing decisions during the nomination process.

Question 2: Chronic Disease

- Instead of laying out a roadmap for how you will improve health care, your testimony points the finger back at the nearly half of Americans who currently live with chronic disease, blaming their conditions on their lifestyle choices.
- Many chronic diseases – diabetes, depression, arthritis – are treatable, but they are not going to simply go away with lifestyle changes.
- If confirmed, what specific actions will you take to improve health care for Americans with chronic diseases and disabilities?

Response: If confirmed, I look forward to working with Secretary Kennedy to make Americans healthy again.

Question for the Record submitted to Mehmet Oz from Senator Smith.

Question 1: Tribal Input at CMS

For more than 20 years, the Tribal Technical Advisory Group (TTAG) has served a critical role at CMS, providing recommendations and input to CMS on any policies or programs impacting AIANs. And the Department of Health and Human Services Secretary's Tribal Advisory Committee (STAC) provides critical insight into priorities of Tribal Nations across the Department.

If confirmed, will you maintain TTAG at CMS? If you make changes to TTAG, will you commit to engaging in Tribal consultation before effectuating these changes?
If confirmed, will you commit to taking STAC's feedback into account and engaging in meaningful Tribal consultation for any proposed administrative changes to the Medicaid and Medicare programs?

Will you commit to ensuring positions on both these advisory committees are filled in a timely manner?

Response: I share Secretary Kennedy's commitment to native communities. If confirmed, I intend to uphold the Agency's legal, social, and moral obligations for the health services promised to American Indian and Alaska Native communities. I will work closely with the President and the Secretary to determine how we can best meet the needs of American Indian and Alaska Native communities on Medicare and Medicaid while improving their health outcomes.

Questions for the Record submitted to Mehmet Oz from Senator Warnock

1. In your opening testimony, you said "Medicaid is the number one expense for most States, consuming 30 percent of their budgets and crowding out essential services like schools and public safety." In order to maintain the current level of healthcare services, will states have to spend more or less money on healthcare if the federal government cuts up to $880 billion in federal funding for Medicaid? If states must spend more money on healthcare due to federal cuts, will they have more or less funding for services like schools, public safety, and optional Medicaid benefits or programs?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to in modernize our tools to reduce fraud, waste and abuse.

2. In our hearing exchange, you said you believed that work reporting requirements "should not be used as an obstacle - a disingenuous effort to block people from getting on Medicaid."[1] The Congressional Budget Office scored Medicaid work requirements as saving the federal government $109 billion over ten years and leading to at least 600,000 people becoming uninsured.[2] Meanwhile, the Center on Budget and Policy Priorities estimates that up to 36 million Americans would be at risk of losing their health coverage under federally mandated work requirements.[3]
    a. How does adding work reporting requirements to Medicaid save money?

[1] Senator Reverend Warnock Questions Dr. Oz at Senate Finance Committee Hearing, YouTube, (Mar. 14, 2025), https://www.youtube.com/watch?v=LijAU0-d6IU
[2] CBO's Estimate of the Budgetary Effects of Medicaid Work Requirements
Under H.R. 2811, the Limit, Save, Grow Act of 2023, Congressional Budget Office, (Apr. 26, 2023), https://www.cbo.gov/system/files/2023-04/59109-Pallone.pdf
[3] Gideon Lukens and Elizabeth Zhang, *Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage*, Center on Budget and Policy Priorities, (Feb. 5, 2025), https://www.cbpp.org/research/health/medicaid-work-requirements-could-put-36-million-people-at-risk-of-losing-health

b. If confirmed as the Administrator of CMS, how would you ensure that any potential federal work reporting policy would not serve as an obstacle or disingenuous effort to block people from getting on Medicaid?

3. Former CMS Administrator Seema Verma approved a Section 1115 waiver with work reporting requirements in Arkansas in 2018. As a result of the program, more than 18,000 enrollees lost health coverage in just nine months.[4] Studies and analyses found that the work reporting requirements were confusing and made Medicaid inaccessible for thousands of Arkansas residents. If confirmed, would you view similar proposals to Arkansas' 2018 waiver as an obstacle or disingenuous effort to block people from getting on Medicaid?

Response (2-3): At the Senate Finance Committee hearing, you and I agreed on the value of a work ethic and the purpose that work provides. I look forward to empowering states with the flexibility to tailor their Medicaid program in ways that best serve their populations while efficiently using taxpayer dollars and promoting personal responsibility.

4. If confirmed as CMS Administrator, you would oversee the Medicaid program, which is vital to over 37 million children across the country and over 1.4 million in Georgia alone.[5] How will you prioritize the unique needs of children and pediatric providers as you develop your priorities at CMS?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

5. The budget resolution passed by the House of Representatives directs the House Energy and Commerce Committee, which has jurisdiction over Medicaid programs, to find $880 billion in savings. According to reports, including by the Congressional Budget Office, achieving this level of savings would require cuts to Medicaid.[6] If Congress were to enact these cuts, and if confirmed, how will you work at CMS to ensure that children and families who rely on Medicaid can continue to access needed care?
6. Should Medicaid cuts be enacted by Congress, how will you ensure that health care providers can financially sustain their work?
7. Should Medicaid cuts be enacted by Congress, how will you prioritize the needs of rural hospitals and prevent further closures of hospitals in underserved communities?

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[4] Akeiisa Coleman and Sara Federman, *Work Requirements for Medicaid Enrollees*, The Commonwealth Fund, (Jan. 14, 2025), https://www.commonwealthfund.org/publications/explainer/2025/jan/work-requirements-for-medicaid-enrollees

[5] *Monthly Child Enrollment in Medicaid and CHIP*, KFF, (Oct. 2024), https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[6] Mandatory Spending Under the Jurisdiction of the House Committee *on Energy and Commerce*, Congressional Budget Office, (Mar. 5, 2025), https://www.cbo.gov/system/files/2025-03/61235-Boyle-Pallone.pdf

Response (5-7): If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

8. Lack of access to mental health services is a crisis in our country, but especially among children. As a Senator, I care deeply about this issue, and I introduced the *Advancing Student Services In Schools Today Act* (ASSIST) *Act*, which would increase federal Medicaid spending for schools to be able to hire and retain mental health counselors.[7] If confirmed, how will you ensure that the Medicaid program better supports provider capacity to improve access to mental health services for children?

   Response: I share your interest in ensuring that children have access to the mental health services they need. If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

9. Medicaid provides children access to medically necessary services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. In September, CMS released guidance to states outlining their statutory requirements and best practices to assist states in properly implementing the EPSDT benefit.[8] If confirmed, how will you continue to work with states and pediatric providers to ensure that children covered by Medicaid are getting access to these necessary services?

   Response: EPSDT is important to ensuring that children and adolescents receive appropriate preventive, dental, mental health and specialty services. If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

10. On his first day in office, President Trump revoked Biden-era Executive Order 14087, titled *Lowering Prescription Drug Costs for Americans*.[9] Part of this EO, from October 2022, allows the Center for Medicare and Medicaid Innovation (CMMI) to launch a voluntary model to test outcomes-based agreements for cell and gene therapies, with a focus on Sickle Cell Disease (SCD). Before revoking the EO, the program secured agreements with manufactures of two sickle cell treatments.
    a. If confirmed, will you ensure that cell and gene therapies demonstration program continue?

[7] ASSIST Act, S. 1774, 118th Cong. (2023).
[8] Biden-Harris Administration Releases Historic Guidance on Health Coverage Requirements for Children and Youth Enrolled in Medicaid and the Children's Health Insurance Program, Centers for Medicare & Medicaid Services, (Sept. 26, 2025), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-releases-historic-guidance-health-coverage-requirements-children-and
[9] *Initial Recissions of Harmful Executive Orders and Actions,* The White House, (Jan. 20, 2025), https://www.whitehouse.gov/presidential-actions/2025/01/initial-rescissions-of-harmful-executive-orders-and-actions/

b. How will you ensure that SCD patients have expeditious access to innovative therapies as they become available?

Response (a-b): I have taken care of patients with sickle cell disease, and it is a devasting disease. I agree that innovative treatment models are needed in this area and the cell and gene therapy model is one of these approaches. If I am confirmed, I will work with Secretary Kennedy, Congress, and stakeholders to ensure that the Innovation Center tests appropriate, innovative models that improve the quality of care for patients and reduces costs for beneficiaries, including those with sickle cell disease.

11. Children's Healthcare of Atlanta (CHOA) has the largest pediatric sickle cell program in the country.[10] Continuity of care, from pediatric to adulthood, is a challenge in the SCD community. Gaps in this care are associated with more hospital visits and higher health care costs.[11] If confirmed as CMS Administrator, what specific steps will you take to help close these gaps in care?

Response: I have taken care of patients with sickle cell disease, and it is a devasting disease. I agree that innovative treatment models are needed in this area and the cell and gene therapy model is one of these approaches. If I am confirmed, I will work with Secretary Kennedy, Congress, and stakeholders to ensure that the Innovation Center tests appropriate, innovative models that improve the quality of care for patients and reduces costs for beneficiaries, including those with sickle cell disease.

12. Enhanced premium tax credits that help more than 1.2 million Georgians, across every congressional district, afford insurance plans purchased on the Marketplace are set to expire at the end of 2025. If these tax credits expire, premiums for a 60-year-old couple earning $82,800 a year would increase by $16,114 annually, and a family of four earning $129,800 a year would see an increase of $6,395 annually.[12]
    a. Do you believe these tax credits help hardworking Americans afford health coverage?
    b. Do you support Congress extending these tax credits?
    c. If Congress does not extend these tax credits, how would you, if confirmed, work to prevent health care premiums from dramatically spiking for millions of Americans?

Response: If confirmed I will ensure Americans have access to affordable, high-quality coverage through the programs CMS administers including the ACA Marketplace.

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[10] *Sickle Cell Disease Program,* Children's Healthcare of Atlanta, https://www.choa.org/medical-services/cancer-and-blood-disorders/blood-disorders/sickle-cell-disease

[11] Gaps in Transition From Pediatric to Adult Care for Individuals Living with Sickle Cell Disease Associated with More Hospital Visits, American Society of Hematology, (May 29, 2024), https://www.hematology.org/newsroom/press-releases/2024/pediatric-transition-gaps-for-individuals-living-with-scd-associated-with-more-hospital-visits

[12] *Georgia: State Impact*, Keep Americans Covered, (Jan. 2025), https://americanscovered.org/wp-content/uploads/2025/01/202501_1P_Enhanced_Tax_Credit_State_Georgia.pdf

13. There are proposals by Republicans in Congress to cap state Directed Payment Program reimbursement rates at the Medicare equivalent. In Georgia, this would result in over $1 billion in reduction in payments to hospitals who are trying to serve patients.[13]
    a. If Congress does enact this cap, how would you, if confirmed, work to prevent reductions in payments to Georgia hospitals, particularly our rural hospitals?
    b. If confirmed, will you advocate to protect the Directed Payment Programs that are important to my state?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

14. According to the Kaiser Family Foundation, nearly all Medicare Advantage beneficiaries are enrolled in plans that require prior authorization for some services.[14] In 2018, the Department of Health and Human Services Office of the Inspector General reported that Medicare Advantage plans overturned 75 percent of their prior authorization denials once appealed.[15] The American Medical Association surveyed providers who said that for 82 percent of them, prior authorization can at least sometimes lead to treatment abandonment, affecting enrollees access to care.[16] If confirmed, how will you hold Medicare Advantage plans accountable for their unnecessary use of prior authorizations?

15. If confirmed, how will you address harmful delays due to prior authorization that compromise patient safety?

Response (14-15): It is important for Medicare beneficiaries to have access to the healthcare they need. If confirmed, I look forward to working at CMS and with Congress to ensure prior authorization is used appropriately.

16. In a decade, 18 hospitals have closed in Georgia, 75 percent of which were in rural communities.[17] Rural hospitals, which often operate on very small margins, cite significant delays in timely payments from Medicare Advantage (MA) plans.[18] If

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[13] *State Directed Payment Programs*, Georgia Department of Community Health, https://dch.georgia.gov/programs/state-directed-payment-programs

[14] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, *Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization,* KFF, (Aug. 8, 2024), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

[15] Daniel R. Levinson, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, U.S. Department of Health and Human Services Office of Inspector General, (Sept. 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

[16] *2024 AMA prior authorization physician survey,* American Medical Association, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[17] Sofi Gratas, *To stay open, rural hospitals need local patients. Two hospitals in Georgia hope to bring them back*, GPB, (Aug. 7, 2024), https://www.gpb.org/news/2024/08/07/stay-open-rural-hospitals-need-local-patients-two-hospitals-in-georgia-hope-bring

[18] *Rural Medicare Advantage*, National Rural Health Association, https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/rural-medicare-advantage.pdf

confirmed, how will you protect rural hospitals from these harmful practices by MA plans?

Response: It is important that rural hospitals remain available to provide care to America's seniors and that they receive timely payments for services provided. If confirmed, I plan to look at all the options to protect and support access to health care, including in rural communities, with the goal of making Americans healthy again.

17. As you are aware, Congress has finalized funding for Fiscal Year (FY) 2025 and will begin the process of assessing funding for FY 2026.
    a. Do you believe that CMS currently has the funding and resources needed to effectively address the obesity epidemic?
    b. If not, what level of funding increase is needed to effectively address obesity in health care programs under CMS' purview?
    c. What substantive changes, if any, would you make to these obesity prevention, care or treatment programs?

Response: If confirmed, I look forward to working with Secretary Kennedy to make Americans healthy again.

18. Community Health Workers improve access to preventive care and assist with chronic disease management that can help keep people healthy while also reducing costly emergency room visits, hospitalizations and poor health outcomes.[19] At least 29 states cover Community Health Worker services under their state Medicaid programs.[20] Additionally, the 2024 Medicare Physician Fee Schedule Final Rule included updates that allow for Medicare coverage of Community Health Worker services.[21] Do you support Medicaid and Medicare reimbursement for Community Health Worker services?

Response: If confirmed, I look forward to following the law and working with you to learn more about this issue.

19. In your view, what is Medicaid's role in allowing older adults and individuals with disabilities to live in their homes instead of premature or avoidable placement in nursing facilities or other institutional care facilities?

Response: If confirmed, I look forward to following the law and ensure that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens.

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[19] Sweta Haldar and Elizabeth Hinton, *State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services,* KFF, (Jan. 23, 2024), https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/

[20] Id.

[21] *Changes to 2024 Medicare Physician Fee Schedule for CHI Services*, Association of State and Territorial Health Officials, (Apr. 8, 2024), https://www.astho.org/topic/resource/changes-to-2024-medicare-physician-fee-schedule-for-chi-services/

20. My office frequently hears from stakeholders about lengthy approval times and delays in communication with officials at CMS. What is your plan to improve efficiency, reduce approval times, and reduce response times at CMS, especially as the Administration is making large workforce cuts to the agency?

    Response: If confirmed, I look forward to ensuring that CMS improves efficiency, reduces approval times, and reduces response times at the agency while making Americans healthy again.

21. In order for Medicare Part A to cover skilled nursing facility (SNF) care, a beneficiary must be admitted to a hospital for three days under inpatient status. I have heard from some of my constituents where SNF care was not fully covered by Medicare because the hospital stays were classified as observation rather than inpatient. What are your views on this 3-day rule, and do you have plans to reform it?

    Response: If confirmed, I will review statutory and regulatory requirements regarding the 3-day rule and will work with Congress to ensure that Medicare beneficiaries have access to the care they need when they leave the hospital.

22. Over the last few years, the federal government has improved access to continuous care for mothers and children, including by mandating 12 months continuous eligibility for kids, allowing states to adopt 12 months postpartum coverage, and funding the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. If confirmed, how will you maintain and build on the work done over the last several years to address the maternal and infant mortality crisis?

    Response: Improving access to care and health outcomes for mothers and children is an important goal. If confirmed, I will examine maternal care policies and programs within CMS and look forward to working with you to make all Americans healthy again.

23. As mentioned, to minimize coverage loss, Congress mandated 12 months of continuous coverage for children starting in January 2024. Several states are taking this a step further by providing multi-year for young children up to age six. Do you support states minimizing coverage gaps for children through multi-year continuous eligibility waivers?

    Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

24. If confirmed, how would you ensure that Medicare Advantage (MA) beneficiaries have adequate and timely access to the specialized expertise and advanced treatments available at National Cancer Institute-designated comprehensive care centers?[22]

[22] *Find a Cancer Center,* National Cancer Institute, https://www.cancer.gov/research/infrastructure/cancer-centers/find

a. If confirmed, how will you address the issue of narrow MA networks that frequently exclude these facilities?

Response: If confirmed, I look forward to examining the network adequacy standards that are applicable to Medicare Advantage and safeguarding seniors' access to care.

25. How will you ensure that Medicare Advantage plans are held to the same transparency and accountability standards as Traditional Medicare?
    a. Would you support establishing a system of oversight for Medicare Advantage?

Response: If confirmed, I will work to find ways to improve transparency, accountability, and access in the Medicare Advantage program.

26. Approximately one quarter of nursing homes in Georgia have a one-star rating from CMS.[23] Georgia is not the only state with significant numbers of nursing homes with poor quality ratings. How will you address this significant number of poorly performing facilities?
    a. How will you ensure our nation's rapidly aging population can receive high-quality care in nursing homes?

Response: If confirmed, I will work to ensure nursing home residents receive safe, high-quality care.

27. According to the Georgia Department of Public Health, over 130,000 Georgians are estimated to have Alzheimer's disease or related dementia.[24] Individuals may be able to stay at home with family caregivers for part of the progression of the disease, but families must often face the difficult decision to move their loved one to a long-term care facility. What will you do to promote more research related to caring for individuals with Alzheimer's disease and other dementias?
    a. If confirmed, how will you improve access to Medicare and Medicaid for individuals with Alzheimer's disease and other dementias?

Response: If confirmed, I look forward to working with you on this issue.

28. There are approximately 10,000 youth in Georgia's foster care system on any given day.[25] Most of the children in foster care have Medicaid coverage. Additionally, young adults aging out of foster care are also eligible for Medicaid until age 26 to ensure that they have medical coverage during a pivotal period in their lives. If confirmed, how will

[23] *Nearly Half of Georgia's Nursing Homes Receive Less than a Three-Star Rating,* Blasingame, Burch, Garrard, and Ashley, P.C., (Sept. 16, 2020), https://www.bbga.com/press/nearly-half-of-georgias-nursing-homes-receive-less-than-a-three-star-rating/

[24] *Alzheimer's Disease*, Georgia Department of Public Health, https://dph.georgia.gov/AlzheimersDisease#:~:text=Over%20130%2C000%20Georgians%20of%20all,an%20increase%20of%20about%2046%25.

[25] *Child Welfare Data,* Georgia Department of Human Services, https://dhs.georgia.gov/division-family-children-services-child-welfare

you work with states to minimize coverage gaps for children, including for foster youth and former foster youth through age 26?

Response: Foster youth face unique challenges with respect to health coverage. If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

Questions for the Record submitted to Mehmet Oz from Senator Roger Marshall, M.D.

Medicare Advantage (MA)

For the past several years, I've been leading the Improving Seniors' Timely Access to Care Act; bipartisan, bicameral legislation that would protect seniors from unnecessary delays and denials of medically necessary care by streamlining and standardizing prior authorization in MA.

Last year, this bill gained a majority in the House, a super majority in the Senate, and would cost the American taxpayers nothing. The bill is supported by more than 500 of the leading health care groups and even gained insurer support. My colleagues in Congress and I will be re-introducing the bill soon and we intend to get it signed into law.

Question #1: Will you commit to working with me and my colleagues to improving the prior authorization process through agency action and by supporting our legislation however possible?

Aggressive prior authorization tactics by MA plans and Managed Medicaid Organizations are increasingly targeting clinical laboratories, resulting in denied payment for medically necessary testing services performed. Payers take advantage of the workflow processes of clinical laboratories to deny payment and are rejecting claims solely based on a test requisition form, which is the only medical documentation a clinical laboratory receives to perform its services. I am concerned that these unfair tactics could ultimately reduce patient access to these critical services. Doctors should decide what tests should be performed to care for their patients, not insurance companies or AI.

Question #2: As CMS administrator, what specific steps will you take to put a stop to unreasonable and aggressive prior authorization tactics that harm our patients and our health care system, including our clinical laboratories?

Question #3: What can CMS do to ensure that the information labs receive is accepted by MA as sufficient for coverage under prior authorization policies?

It is currently estimated that Medicare Advantage plans are overpaid by $1.0 to $1.4 trillion over a ten-year budget window.

Question #4: What would you do to address these overpayments?

Question#5: With the administration heavily focused on waste, fraud, and abuse, do you think these overpayments to MA plans should be considered for improving the programs integrity?

Response (1-5): As I said in the hearing, it is important for Medicare beneficiaries to have access to the healthcare they need, and if confirmed, I will work to ensure that Medicare Advantage is delivering access to high-quality care while taking steps to root out waste, fraud, and abuse.

Price Tags in Health Care

In his first term, President Trump promulgated strong regulations to require hospitals and health insurers to reveal all their actual prices and negotiated rates. Last month, he issued an Executive Order that doubled down by calling for CMS to implement "radical price transparency."

The Biden administration implemented the new rules, but enforcement, according to the GAO, was minimal and not consistent. Many hospitals failed to meet the requirements with no penalties. Further, the Biden administration rolled back the rule, allowing hospitals to post estimates and historical averages instead of actual prices.

Question #6: If confirmed, how do you plan to "fulfill the promise of radical transparency" to empower patients and employer and union health plans to choose affordable care and benefit from competition?

Question #7: According to a recent report by PatientRightsAdvocate.org, only 21.1% of hospitals nationwide are fully complying with a bipartisan federal hospital price transparency rule. How would you compel all hospitals to accurately post all of their actual prices in a format patients can understand?

The federal Transparency in Coverage rule is designed to empower healthcare consumers with the amounts that health plans will reimburse their doctors and other health providers before they receive the care and to ensure their bills are correct. Unfortunately, the rollout of the rule has resulted in massive and unwieldy insurance price files that even experienced researchers cannot parse.

Question #8: Will you commit to investing the resources necessary to making this critical information usable by patients as well as employer and union plans?

Response (6-8): President Trump implemented historic price transparency requirements on hospitals and health plans to ensure consumers have the pricing information they need to make the best care decisions for themselves and their families. If confirmed, I will implement the Executive Order entitled "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" and will take all necessary steps to improve existing price transparency requirements; increase enforcement of price transparency requirements; and identify opportunities to further empower patients with meaningful price information.

Food is Medicine

During the first Trump administration, CMS published a 51-page guidance document describing "Opportunities in Medicaid and CHIP to Address Social Determinants of Health," touting the flexibility it was giving to states through 1115 waivers through what Trump's CMS called a "new roadmap." As an example, they pointed to their approval of North Carolina's 1115 Medicaid waiver that can provide medically tailored meals, or food is medicine, to individuals with medical dietary needs, such as those with diabetes.

Question #9: How will the agency continue to support promising interventions like food is medicine in Medicaid?

Response: If confirmed, I would work to partner with states to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

Question #10: What incentives could CMS put in place to encourage plans to offer food is medicine benefits and how can CMS support MA plans that want to provide food is medicine?

Response: Medicare Advantage provides an opportunity for beneficiaries to access additional choices and benefits. If confirmed, I will work to find ways to improve the Medicare Advantage program, including by looking at ways to support plans in providing benefits to meet their enrollees' needs and make Americans healthy again.

IRA

As CMS implements the Inflation Reduction Act (IRA)'s negotiated prices for selected drugs, there is significant concern the CMS model established by the Biden administration will destroy pharmacies financially. According to the NCPA, over 90% of community pharmacies are deciding not to stock or are strongly considering not stocking selected drugs because of the negative financial impact. This will have significant implications for Medicare patients, particularly in rural areas, who may lose access these drugs. We need the new leader of CMS to step in and fix these issues left behind by the Biden administration to ensure our pharmacies can serve our seniors.

Question #11: Will you work to address their concerns and ensure patients have continued access to their medication?

Response: Lowering the cost of prescription drugs for Americans is a top priority of President Trump and this Administration. If confirmed, I plan to look at all options to protect and support access to medications, including in rural communities, for America's seniors.

Hospitals

Question #12: How do you view CMS's role in ensuring Medicare reimbursement rates remain sustainable for rural hospitals and providers, particularly given the unique financial pressures these facilities face?

Response: If confirmed, I plan to look at all options to protect and support access to health care, including in rural communities, with the goal of making Americans healthy again.

Question #13: What steps will CMS take to reduce unnecessary regulatory burdens on hospitals, especially regarding reporting requirements that divert resources away from direct patient care?

Response: If confirmed, I look forward to taking steps to cut unnecessary red tape and ensure that all patients can get the care they need.

Diabetes

Question #14: If you were confirmed to be CMS Administrator, what steps would you take to achieve the Make American Healthy Again agenda for the programs and services under CMS purview particularly as it relates to reversing the escalating trends of diabetes and obesity?
As you know, diabetes is a chronic disease that impacts 29% of our seniors, with many Medicare beneficiaries needing an insulin pump per American Diabetes Association clinical practice guidelines and their physicians' orders. As a physician, you understand the importance of managing diabetes consistent with clinical guidelines that include appropriate use of technology.

Question #15: Will you commit to working with this Committee to address any outdated clinical requirements so that Medicare covers insulin pumps for beneficiaries who need them?

Response (14-15): If confirmed, I will work with Secretary Kennedy to ensure that CMS programs are well administered, effective, and available for eligible beneficiaries in line with the Make America Healthy Again agenda. I understand that Medicare and Medicaid play key roles in shaping how diabetes care is delivered and look forward to working with you on this important issue.

Organ transplant

I am concerned about the misalignment of CMS performance measures for organs procurement organizations (OPOs) that recover and offer organs from deceased donors for transplantation, and transplant programs that decide whether to accept OPO organ offers on behalf of their patients. Under the measures established by CMS in 2020, OPOs face decertification if they are ranked below the top 25th percentile (as compared against the country's other OPOs) for the number of organs they recover that are transplanted (a decision made by transplant surgeons – not OPOs). Transplant programs are evaluated by CMS on post-transplant patient outcomes including whether transplanted organs function successfully after transplantation and therefore have a strong incentivize to hold out for younger, healthier organs of which there is an extremely limited supply.

Question #16: Will you agree to work with the organ donation and transplant community to correct this misalignment?

Response: As a cardiothoracic surgeon who has performed critical lifesaving transplants, I am deeply committed to improving the organ donation and transplantation system. If

confirmed, I look forward to working closely with Congress on accomplishing this goal, including holding OPOs accountable.

Questions for the Record submitted to Mehmet Oz from Senator Maria Cantwell.

Question 1: Emergency Abortions

Several state abortion bans are so extreme that doctors aren't sure whether they can legally end a pregnancy to prevent death, future infertility, or organ damage. In these states, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency rooms to provide stabilizing care to patients in emergencies. That way, doctors don't have to worry they'll go to jail for saving their patients' life. As CMS Administrator, you would be responsible for implementing and enforcing EMTALA to ensure that hospitals are providing emergency care. But the Trump administration has shown so far that it does not care if pregnant women die in medical emergencies. Just this month, the administration dropped a lawsuit against Idaho over its extreme abortion ban, which conflicts with federal requirements under EMTALA.
QUESTIONS:

1. If you are confirmed as CMS Administrator, you will be responsible for implementing and enforcing EMTALA. Will you commit to maintaining the current emergency care guidance?
2. What do you personally think about the Trump administration's decision to drop out of the Idaho litigation?

Response (1-2): If confirmed, I will follow the law.

Question 2: Prescription Drugs

While I do not support the sledgehammer approach that the Trump Administration and DOGE are using, I agree that there are areas that we can cooperate on to cut health care costs. One of these areas is the cost of prescription drugs. The federal government is the nation's largest purchaser of prescription drugs, but until Congress passed the Inflation Reduction Act (IRA) in 2022, it did not have the ability to negotiate with drug manufacturers. I believe that if you buy in bulk, you should get a discount.

That is exactly what the IRA provided. The first 10 drugs chosen for price negotiations alone are expected to save $6 billion for the federal government. We also need to look at the unfair and deceptive practices of Pharmacy Benefit Managers (PBMs). Last year, the Federal Trade Commission released a report which found that the three largest PBMs significantly marked up prices for specialty generic drugs – some by over 1,000%.

The report also found that PBMs made $1.4 billion in income from spread pricing, a practice where PBMs charge insurance plans, including Medicare prescription drug plans, more and reimburse pharmacies less while pocketing the difference. Ultimately, patients and taxpayers shoulder the burden of these harmful practices.

QUESTIONS:

1. Do you support the bipartisan Pharmacy Benefit Manager Transparency Act that I introduced with Senator Chuck Grassley, which is estimated to save the government $740 million over 10 years?

   Response: The role played by PBMs in prescription drug pricing and pharmacy reimbursement is an issue of concern to President Trump, myself, and to many Americans. I believe increased transparency in PBM practices would help CMS better examine what is happening in the drug market. If confirmed, I look forward to working with Congress on this issue.

2. Will you commit to upholding the IRA's Medicare drug pricing program, which will generate even more savings as more drugs are chosen for negotiations?

   Response: If confirmed, I plan to follow the law in implementing CMS programs and I look forward to working to lower prescription drug prices for all Americans.

Question 3: Medicaid

Medicaid is a critical piece of the health care system. Nearly 2 million people are enrolled in Apple Health, Washington's Medicaid program. That's 25 percent of Washingtonians. Washington's hospitals received $3.36 billion in Medicaid payments last year. That's why I'm so alarmed by talk about Medicaid cuts.

QUESTIONS:

1. Do you support or oppose cutting federal Medicaid funding?

2. As of June 2024, 625,573 Washingtonians were enrolled in Medicaid through the ACA expansion. Will you commit to protecting coverage for people on Medicaid through the expansion?
3. Medicaid funds important home and community-based services, including the Money Follows the Person program.

a. Will you commit to both continuing the Money Follows the Person program and providing adequate Medicaid funding for it?

Response (1-3): If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

Question 4: Tribal Health

1. If confirmed, will you support protecting the 100% Federal Medical Assistance Percentage (FMAP) for IHS services?

a. Would you support the extension of 100% FMAP for Urban Indian Organizations and the Native Hawaiian health care system?

Response: I share Secretary Kennedy's commitment to native communities. While decisions about federal match rates and Medicaid funding are made by Congress, I

am committed to improving healthcare quality and outcomes for all Americans, including Native Americans, and Medicaid is an important program to support that goal. If confirmed, I would work as CMS Administrator to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while improving health outcomes.

2. Should Indian Health Service (IHS) beneficiaries be subject to work or other eligibility requirements as a condition for Medicaid coverage? Why or why not?

   Response: I share Secretary Kennedy's commitment to native communities. I am committed to improving healthcare quality and outcomes for all Americans, including Native Americans, and Medicaid is an important program to support that goal. If confirmed, I would work as CMS Administrator to ensure that the Medicaid program addresses the unique needs of native communities.

Question 5: Sepsis and Blood Culture Contamination

For the past several years, clinicians, hospital quality leaders, and laboratory experts have asked CMS to add the Centers for Disease and Control and Prevention's (CDC) new Adult Blood Culture Contamination Rate measure to CMS's Hospital Acquired Conditions (HAC) prevention program. CDC's quality measure targets movement towards the elimination of false-positive diagnostic tests for bloodstream infections including sepsis (the leading cause of death, costs, and readmissions in hospitals nationwide). This measure proposes monthly reporting of hospital blood culture contamination rates which every accredited hospital in the U.S. is already required to track.

By achieving the CDC's new benchmark quality measure of maintaining 1 percent or fewer blood culture contaminations, hospitals will improve patient safety, prevent unnecessary and harmful treatments, and directly and immediately address accelerating antimicrobial resistance concerns. Many peer-reviewed clinical studies have found that false-positive bloodstream infection/sepsis test results negatively impact nearly 2 million American from fully preventable harm (including significant avoidable morbidity and mortality) each year. These studies also show that false-positive bloodstream infection/sepsis test results lead to nearly $10 billion in wasteful medical spending in the U.S. every single year.

QUESTIONS:

1. Will you commit to collaborating with the CDC to ensure that CMS addresses this patient safety issue by considering adding the CDC quality measure to CMS's HAC program this year?

   Response: If confirmed, I look forward to work with you to learn more about this issue.

Questions for the Record submitted to Dr. Mehmet Oz from Senator Bennet

Question 1. If the Republican-proposed Medicaid cuts are adopted, people will lose coverage. The House Republican Medicaid cuts on the table to pay for reconciliation will lead to more people being uninsured and underinsured, as states will have no choice but to cut benefits or

reduce eligibility. With more people uninsured and underinsured, hospitals and community health centers will have more uncompensated care, many of whom are already operating on razor thin margins.

Hospitals, health centers, physician practices, and nursing homes will close. Since 2010, 150 rural hospitals have closed their doors or have been forced to close essential departments like obstetrics. These closures happen disproportionately in states that did not expand Medicaid - hospital closures increased by 110% in non-expansion states but fell by 65% in expansion states.

This will not only lead to less access for patients, but also job losses, especially in rural areas where hospitals are major community employers. These cuts will have far-reaching effects throughout our health care system. States can't afford it and my constituents can't afford it.

- Are you aware that people will have to pay more for their commercial insurance as a result of these cuts?
- Are you aware that the risk of hospital closure in rural areas is exponentially higher if these cuts go into effect?
- What are you going to do to help protect rural hospitals from closing?
- How would you recommend states come up with the funding shortfalls that will transpire should Medicaid funding be taken away from them?

Response: If confirmed, I plan to look at all the options to protect and support access to health care, including in rural communities, with the goal of making Americans healthy again. If confirmed, I would work to partner with states to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fits the needs of their citizens, ensure quality, and improve health outcomes.

Question 2: If Medicaid is significantly cut, people will lose access to preventive and routine health care, leading to poorer health outcomes over time. As Medicaid beneficiaries age into Medicare, they would likely have more complex and costly medical needs due to unmanaged chronic conditions and delayed treatments earlier in life.

This increased demand for expensive care—such as hospitalizations, specialist visits, and long-term chronic care management—would drive up Medicare spending. That could lead to higher premiums across private and public insurance, reduced benefits, or the need for additional government funding to sustain the program.

- Isn't slashing Medicaid just robbing Peter to pay Paul, and how do you propose to pay for the increased Medicare costs?

Question 3: Both in our meeting and in your testimony to the Finance Committee, you said that you want to focus on our most vulnerable populations, like seniors, young people in poverty, and sick people – the very populations that Medicaid serves. Additionally, one of the main goals of the Administration and Secretary Kennedy is to tackle chronic disease and to make Americans

healthier. And yet, access to health care is critical to keeping people healthy and reducing chronic conditions.

- Do you believe that cutting Medicaid is in contradiction with those goals?

Response (2-3): If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

Question 4: I hear from providers and patients all over Colorado that they are dissatisfied with their Medicare Advantage plans. Providers are frustrated with care being delayed or denied because of insurers' prior authorization requirements, not to mention the increased administrative time – something you have said is a huge problem in our health care system today. Patients are frustrated that they or their loved ones can't get the care they need where and when they need it.

One of my constituents had to wait 14 days for a CT to check for a brain bleed after a fall.

- How will your administration hold insurance companies who are supposed to take care of our seniors accountable for potentially deadly delays in care?
- How would you reform the Medicare Advantage Program to make it more efficient and ensure that patients are getting the services that they signed up for in a timely manner?

Response: It is important for Medicare beneficiaries to have access to the healthcare they need. If confirmed, I look forward to working at CMS and with Congress to ensure access to care for Medicare beneficiaries.

Question 5: Project 2025 proposes to make Medicare Advantage (MA) the default option for seniors, taking away the very choice in health care that MA was supposed to provide seniors, and effectively eliminating traditional Medicare. Americans want more options that are higher quality, more affordable, and not driven by stakeholder profits.

- Will you oppose efforts to make Medicare Advantage the default plan for seniors entering Medicare?

Response: Seniors deserve to have choices for accessible, high-quality care. Both traditional Medicare and Medicare Advantage are important for giving seniors this choice. If confirmed, I would work to ensure that both traditional Medicare and Medicare Advantage are well administered, effective, and available for eligible beneficiaries.

Question 6: Advanced premium tax credits, which help make health insurance more affordable, are set to expire at the end of this year. If that happens, the average Colorado household premium spending would increase 50%; the average Colorado household premium spending in rural Colorado will increase 73%, and the average Colorado household premium spending for 60-64 year-olds will increase 78%.

- Do you support extending advanced premium tax credits so they do not expire at the end of the year?

- If they expire, what would you say to families who can no longer afford health insurance should these tax credits expire? Without insurance, where would you advise they go when they or their kids get sick?

Response: If confirmed I will work to ensure Americans have access to affordable, high-quality coverage through the programs CMS administers including the ACA Marketplace.

Questions for the Record submitted to Mehmet Oz from Senator Ben Ray Lujan.

Question 1: Mobile stroke units (MSUs), are specially equipped emergency transport vehicles with staff and equipment to respond to suspected stroke calls and can diagnose and subsequently treat a stroke victim within minutes of their arrival. However, MSUs face ongoing financial challenges due to insufficient reimbursement under the Ambulance Fee Schedule. With Secretary Kennedy focused on reducing the burden of chronic disease and the known health and financial burdens associated with stroke, interventions like MSUs are one way to improve outcomes. Will you commit to exploring how to appropriately reimburse for the specialized care provided by MSUs?

Response: If confirmed, I look forward to learning more about this issue and exploring options to address it.

Question 2: New Mexico has a unique history of successfully integrating midwives into our health care system. The Medicaid Birthing Options Program has increases access to essential birthing options in New Mexico by ensuring that midwives are reimbursed at 75% to 98% of the rate paid to physicians. Will you commit to protecting Medicaid coverage for birthing options for pregnant mothers? Will you commit to protecting Medicaid reimbursement for the services that midwives provide?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries.

Question 3: On March 10, 2025, CMS issued a Marketplace Integrity and Affordability Proposed Rule, which by the agency's estimates will result in between 750,000 and 2 million individuals losing health care coverage. What steps will you take to ensure that individuals, whose coverage would be taken away should this rule be finalized, can still receive health care coverage?

Response: If confirmed, I will follow the law and work to foster an affordable, accessible, high quality health care system that best meets the needs of individuals and their families while protecting them from the high premiums caused by waste, fraud, and abuse

Question 4: Last month, CMS announced that the ACA Navigators program funding would be slashed by almost 90%. What is your plan to support open enrollment on the ACA Marketplace and ensure low uninsured rates in the absence of ACA Navigators?

Response: If confirmed, I will follow the law and work to foster an affordable, accessible, high quality health care system that best meets the needs of individuals and their families while protecting them from the high premiums caused by waste, fraud, and abuse.

Question 5: Will you commit to working with Congress to expand Inflation Reduction Act policies to lower drug prices for more Americans? How will you use your existing authorities, if confirmed, to lower drug prices for people with private insurance?

Response: If confirmed, I plan to follow the law in implementing CMS programs and I look forward to working to lower prescription drug prices for all Americans

Question 6: If confirmed, how will you prioritize efforts to prevent and reduce drug shortages, including for essential medicines and generics?

Response: If confirmed, I look forward to exploring what role CMS can play in reducing drug shortages and ensuring that Americans have access to life-saving therapies.

Question 7: There is limited visibility into the upstream supply chain for pharmaceuticals, making it harder to predict and prevent disruptions and shortages. What actions will you take to improve visibility into the global pharmaceutical supply chains? How will you work to develop appropriate metrics and standards for assessing pharmaceutical supply chain resiliency?
Question 8: Will you commit to working to improve the security and resiliency of U.S. pharmaceutical supply chains, including through efforts to assess, value, and incentivize supply chain resilience?
Question 9: Will you commit to fostering productive public-private partnerships that can provide Congress with key information on pharmaceutical supply chains, help predict shortages, and improve the long-term security and resiliency?

Response (7-9): If confirmed, I look forward to working with Congress to ensure resiliency in our prescription drug markets and maintain access to life-saving therapies.

Question 10: Will you commit to supporting congressional efforts to increase transparency and oversight of into pharmaceutical drug prices, including oversight of Pharmacy Benefit Managers?

Response: Yes.

Question 11: CMS has arbitrarily clawed back millions in funding from pharmacy and allied health residency programs, without explaining how residency programs can share resources like faculty, educational materials, and administrative support efficiently within their health system. Will you commit to providing guidance for these programs so they can know how to efficiently use shared resources within their system while complying with CMS requirements?

Response: If confirmed, I look forward to working with you on this issue.

Question 12: Many states allow their commercial and Medicaid beneficiaries to receive clinical services from their pharmacist as long as those services are within the scope of the pharmacist's training. However, CMS does not allow Medicare beneficiaries access those same covered services from their pharmacist. Will you work with Congress to make sure Medicare beneficiaries can access covered clinical services from their pharmacist?

Response: It is important that Medicare beneficiaries have access to the care that they need from the providers who are best able to meet their needs. If confirmed, I look forward to exploring options to address this issue.

Question for the Record submitted to Mehmet Oz from Senator Mark Warner.

Question 1: Since President Trump took office, he and Elon Musk have illegally fired around 3,500 employees, some of whom have been reinstated and continuing to work, some of whom reinstated under direction of the courts and it's unclear if they are working or being placed on paid administrative leave instead of being allowed to work and serve the American people. Worse than that, the folks who have not been fired and continue to work are living in fear that they will be illegally fired next by leaders not pushing back against a presidential administration that says "we want the bureaucrats to be traumatically affected….We want them to not want to go to work because they are increasingly viewed as the villains." I have heard directly from Virginian federal workers who are still working and share that morale is very, very low; that their workplace is filled with chaos, fear, and uncertainty; and one even wrote "I have served this nation for 40 years, over 20 on active duty in the Army….[the firing of a probationary colleague] is without question the most heartless, unnecessary pain a government has ever inflected on one of its own citizens, and one who wanted to have a life of service."

- OPM has made clear that agencies are ultimately in charge of personnel actions. You have not been at CMS during these recent personnel actions, but if confirmed, you will be entering a workplace of mission-driven patriots who feel like those sentiments above. If confirmed, will you commit to review every personnel action taken since the beginning of this Administration, make your own determination if such action was legal and appropriate, and reinstate everyone fired illegally, in order to build trust with your team that you are the leader who will stand up for them and the work they do serving the nation?

  Response: If confirmed, I will follow the President's directives on personnel.

Question 2: Democrats stabilized the individual and small group health insurance marketplaces by expanding premium tax credits. This expansion expires December 31, 2025, and if the Republican-led Congress and White House do not agree to work with Democrats to further extend them, premiums will rise in 2026.

- Do you support working with Democrats in Congress to extend the expanded premium tax credits?

Response: If confirmed I will ensure Americans have access to affordable, high-quality coverage through the programs CMS administers including the ACA Marketplace.

Question 3: You were a co-founder and on the board of a company called Sharecare. One of its lines of business, Sharecare Health Data Services, served as a vendor to health care providers, as a data intermediary. In May 2018, cyber hackers gained access to your company's systems that contained patient information and exfiltrated that data to locations outside the United States.

- How did the hackers get into your company's system?
- Why did it take 5 months after you discovered the breach for your company to notify your clients that their patients' health data was breached?

Response: Sharecare was hacked in the Summer of 2018 and hired outside experts to help conduct a forensic review of over a dozen companies which Sharecare owned. Through that process, the company learned that thousands of records were potentially implicated, but no data was compromised. The Sharecare Board was informed along with the customers in December, 2018, and had no role in addressing the hack. The HHS Office of Civil Rights reviewed the Sharecare process and agreed that the company handled the hack correctly.

Question 4: In 2024, a gang of cybercriminals found a vulnerability and infiltrated a subsidiary of UnitedHealth Group, stealing the health information of one hundred million patients. On top of that, because of the attack, many doctors could not get paid for weeks. The vulnerability was basic cyber hygiene—lack of multifactor authentication. Worse, UnitedHealth Group knew Change's cybersecurity was lacking. Medicare had to advance payments to health care providers to ensure they were able to make payroll from a breach they had no fault in causing.
In cybersecurity, it's never a matter of if there will be an intrusion but instead when, how and how damaging. And what we've seen in the health care sector is cybersecurity considered as optional, not as the critical patient safety protection it actually us, just like sanitizing equipment for prevent infection. Experts say folks have likely died already from cyber intrusions that have shut down hospitals or prevented providers from knowing critical information like medication allergies.

- The Biden Administration proposed in its last budget to Congress new requirements for hospitals to meet mandatory minimum cyber hygiene standards. Ranking Member Wyden and I also have legislation that would require just that, and would also provide one-time grants to help hospitals make the investments they need. Do you support ensuring no patient should worry about their safety or care being compromised by a cyber incident, because they can know their hospital is meeting mandatory minimum standards?

Response: I share your concern about the impact of data breaches on patients' data and health information. If confirmed, I look forward to working with partners within HHS and with Congress to ensure that American patient data is protected and parties responsible for cybersecurity violations are held accountable.

Questions for the Record submitted to Mehmet Oz from Senator Whitehouse.

Question 1: According to an analysis from the Senate Finance Committee staff, you avoided hundreds of thousands of dollars in Medicare taxes using a maneuver that the Department of Treasury, affirmed by the Tax Court, has found is against the law. You dispute this finding and reportedly plan to wait until higher courts weigh in.
To the extent that there is any legal gray area with respect to your Medicare taxes, my Medicare and Social Security Fair Share Act would ensure that wealthy taxpayers can no longer avoid contributing to Medicare by exploiting this loophole.

Will you work against passage of the bill because of your past reliance on your interpretation of this loophole?

Response: Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. I will continue to follow the law and pay all appropriate taxes.

Question 2: While half of all patients facing end-of-life decisions choose hospice, about half of those make the election too late to fully benefit from the care hospice provides. Many of these individuals experience emergency room visits and hospital stays that could have been avoided. Will you let Rhode Island test the following end of life flexibilities for Medicare beneficiaries? Please confirm regarding each individual flexibility below:

a. Ensuring people do not have to spend three nights in the hospital before the time in a skilled nursing facility is paid for.

b. Allowing families to have their loved one stay in the home, while respite care is provided to relieve caregiver burn out.

c. Not forcing patients to choose between curative and hospice treatment, when they are undergoing one of the toughest times in their lives.

d. Allowing patients nearing death to receive home health services without a requirement that they also be "homebound."

e. Allow for continuity of care for people who use nurse practitioners and physician assistants as their primary care providers, allowing them to certify patients as beneficiaries for hospice care.

Response: As we discussed in your office, we must reexamine how end-of -life care is addressed in this country. If confirmed, I look forward to examining Rhode Island's request and working with you to explore innovative approaches to provide compassionate care for Medicare beneficiaries and their families who must navigate difficult end-of-life decisions.

Questions for the Record submitted to Mehmet Oz from Senator Cortez Masto.

Question 1: States like Nevada rely on flexibilities granted under 1115 and 1332 waivers to administer health care programs that meet local needs. If confirmed, will you commit to fully upholding and preserving the flexibilities granted through existing agreements between CMS and the states?

Response: If confirmed, I will work to see that CMS is a helpful resource to states by providing transparent and clear communication regarding flexibility, technical assistance and support as needed. States are unique in their specific approaches to the provision of services, and, if confirmed, I will examine waivers submitted to CMS consistent with the law.

Question 2: Ground ambulances are vital to community health care, providing emergency response and interfacility transport. A CMS report[26] confirms that transport costs far exceed reimbursement, particularly from Medicare and Medicaid. This funding gap threatens service sustainability. How would you address this reimbursement shortfall in order to protect patient access to ambulance services?

Response: I agree that ground ambulance services are a vital part of community health care, helping patients in times of need, particularly in rural communities. If confirmed, I look forward to working with you and other members of Congress on this issue.

Question 3: During the hearing, you proposed restriction prior authorization to approximately 1,000 essential procedures and implemented a streamlined, automated approved process akin to instant credit card transactions. What specific criteria should CMS use to determine which procedures qualify as essential?

Response: If confirmed, I look forward to working at CMS and with Congress to ensure access to healthcare for Medicare beneficiaries.

Question 4: Do you have any conflicts of interest that would prevent you from fulfilling your duties as CMS Administrator? If so, how do you plan to divest and resolves these conflicts?

Response: In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest. As part of that process, I have consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest.

[26] CMS. Medicare Ground Ambulance Data Collection System (GADCS) Report: Year 1 and Year 2 Cohort Analysis. (December 2024). https://www.cms.gov/files/document/medicare-ground-ambulance-data-collection-system-gadcs-report-year-1-and-year-2-cohort-analysis.pdf

Question 5: You've pledged to divest from certain healthcare companies within three months of confirmation, but your disclosures don't clarify where your $5–$25 million stake in iHerb will go. If you place it in a family trust, will you commit to recusing yourself from CMS decisions that directly affect iHerb throughout your tenure at the agency?

Response: In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest and have entered into an ethics agreement to avoid any actual or apparent conflict of interest. I am committed to upholding the commitments that I have made in the agreement. During that process, I also obtained guidance from the ethics officials to ensure that any required divestitures are accomplished in full compliance with the law and governing regulations. The Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest. If confirmed, I will continue to consult with the appropriate agency ethics officials and act consistently with governing regulations.

Question 6: If confirmed, will you support protecting the 100% Federal Medical Assistance Percentage (FMAP) for IHS services?

Response: I share Secretary Kennedy's commitment to native communities. While decisions about federal match rates and Medicaid funding are made by Congress, I am committed to improving healthcare quality and outcomes for all Americans, including Native Americans, and Medicaid is an important program to support that goal. If confirmed, I would work as CMS Administrator to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while improving health outcomes.

Question 7: If confirmed, how will you ensure that CMS upholds and advances the federal trust responsibility to Tribes and Native Hawaiians, and respects their rights to sovereignty and self-determination in its policies, actions, and resource allocation decisions, particularly through prioritizing budget requests and federal funding allocation, staffing, and policy implementation?

Response: I support American Indians and Alaska Natives and the federal trust responsibility for health care. If confirmed, I will work tirelessly to improve health services to Tribal nations, honor Tribal sovereignty and fulfill our obligations to Native Americans across our agency. We will also work to make sure that we are responsive to the unique needs of Tribal nations.

Questions for the Record submitted to Mehmet Oz from Senator Warren.

Question 1: Will you commit to opposing any and all efforts to privatize or cut Medicare if you are confirmed as CMS Administrator?
Question 2: Do you support any policies that would make MA the default enrollment option for Medicare enrollees? If so, which ones?

Question 3: Do you believe it is important to preserve the traditional Medicare program? If so, how do you plan to preserve the traditional Medicare program, and preserve it such that all seniors have the choice to enroll in it?
Question 4: Do you still continue to support policies that would eliminate Traditional Medicare?

a. If so, how will you address concerns from seniors that will be forced out of the program?

Question 5: How do you reconcile your support for turning Medicare over to private insurers with findings from federal watchdogs and whistleblowers indicating that these private companies overcharge taxpayers and unlawfully deny care? What would you do to ensure that private insurance companies in Medicare do not overcharge taxpayers and unlawfully deny care?

Response (1-5): Seniors deserve to have choices for accessible, high-quality care, whether that be through Medicare or Medicare Advantage. The President has been very clear about his support for Medicare. If confirmed, I would work to ensure that Medicare is well administered, effective, and available for eligible beneficiaries.

Question 6: What measures will you take at CMS to prevent coding abuse and overpayments in Medicare Advantage?
Question 7: What will be your approach to handling the increasing rate of prior authorizations and other limits on Medicare enrollees' care in the Medicare Advantage program?
Question 8: Do you support automatic enrollment in Medicare Advantage?
Question 9: What are your views on the Medicare Advantage benchmark system? How would you combat favorable selection?
Question 10: The Biden administration has taken steps and issued rules to crack down on abuse in Medicare Advantage. Will you commit to implementing these policies?

a. Specifically, will you finalize the CY26 proposed Medicare Advantage rule and the CY26 Advanced Notice for payment policies, including the third-year implementation of the changes to the risk adjustment model?

Response (6-10): Medicare beneficiaries deserve to have choices in how they receive their Medicare benefit, whether that is through original Medicare or Medicare Advantage. If confirmed, I will work to find ways to improve the Medicare Advantage program, including by looking at ways to address systemic upcoding and misuse of prior authorization.

Question 11: Numerous reports have documented high pressure and misleading marketing tactics by insurance brokers seeking to enroll beneficiaries in private plans. What would you do to protect beneficiaries from these marketing strategies?

a. Will you not walk back existing or pending CMS regulations to crack down on misleading marketing in MA?

Question 12: According to the New York Times, you are a licensed insurance broker in more than 20 states. Please list all the states where you are still licensed.
Question 13: Medicare Advantage enrollment has grown significantly in recent years and now outpaces enrollment in Traditional Medicare. What steps would you take to ensure that the program remains financially sustainable while delivering high-quality care to beneficiaries?

Response (11-13): Response: I obtained an insurance brokerage license in order to explore potential business opportunities that I ultimately decided not to pursue. While my registrations may still be active in some states, I am not currently engaged as a broker of insurance products in any jurisdiction. If confirmed, I will seek to ensure that Medicare Advantage, as well as original Medicare, provides seniors with access to the best care while working to ensure program financial sustainability.

Question 14: The five percent of worst performing MA plans are responsible for tens of thousands of needless deaths each year. Would you support allowing beneficiaries to enroll in those plans? If not, how could you prevent it?

Response: I believe beneficiaries should be empowered with better tools and more transparency so they may better navigate their health. If confirmed, I look forward to working on ways to make sure that Medicare Advantage provides access to the highest quality of healthcare for seniors who choose it.

Question 15: Do you support adding an out-of-pocket cap to Traditional Medicare?

Response: If confirmed, I will work to foster an affordable, accessible, high-quality health care system that best meets the needs of all beneficiaries.

Question 16: Given Medicare Advantage plans' incentive to deny care, do you support requiring such plans to use existing Medicare administrative contractors (MACs) or an independent third party to make prior authorization decisions and adjudicate claims based on medical necessity and without conflicts of interest?

Question 17: While you have called traditional Medicare "highly dysfunctional," Traditional Medicare does not have provider network restrictions and requires very little prior authorization, whereas most MA plans have restricted provider networks and 99% of all MA enrollees are subject to prior authorization requirements, most often for higher cost services. Are you supportive of restricted provider networks?

Question 18: An American Medical Association (AMA) 2023 annual survey on prior authorizations found that 93% of physicians reported that prior authorizations led to delays to patients' "access to necessary care," 78% reported that the process can at least sometimes lead to patients abandoning their physicians' recommended course of treatment, and 24% reported that prior authorization has led to a serious adverse event for a patient in their care.

a. Would you call these barriers to care imposed by MA plans "dysfunctional"?
b. Are these estimates of the percentage of patients affected by these MA plan tactics acceptable to you? If not, how do you intend to improve the program?

Question 19: Less than 10% of people appeal MA plan denials, but when they do, more than 80% win their appeal. Does this suggest to you that MA plans are denying more medically necessary care than they should?

Response (16-19): If confirmed, I look forward to ensuring the highest quality of care for seniors. Medicare beneficiaries deserve to have choices in how they receive their Medicare benefit, whether that is through original Medicare or Medicare Advantage. If confirmed, I will work to find ways to improve the Medicare Advantage program.

Question 20: CMS recently limited the times when low-income individuals can join, switch, or leave Medicare Advantage or Part D plans. What are your thoughts about the necessity of an annual enrollment period, which results in intense and often misleading marketing tactics, versus more frequent special election periods to allow low-income beneficiaries to change plans as needed

Response: If confirmed, I look forward to examining ways to ensure that the enrollment and marketing processes work better for people with Medicare.

Question 21: How do you plan to increase enforcement of site-neutral payment requirements in Medicare?

Response: If confirmed, I will follow the law. I also look forward to working with my colleagues at CMS, Secretary Kennedy, Congress, and stakeholders to evaluate the appropriateness of payment rates for hospitals to ensure access to appropriate care in appropriate settings.

Question 22: HHS Secretary Robert F. Kennedy Jr. recently rescinded a 54-year-old department policy – known as the Richardson Waiver – to provide advanced notice and opportunity for public comment on proposed regulations. During the confirmation process, Kennedy promised U.S. senators that he would usher in a "new era of radical transparency" at HHS. Which version of Kennedy do you side with?
Question 23: Do you commit to following 54 years of precedent and inviting full public notice and comment to any and all proposed CMS regulations?
Question 24: Will you use the Richardson Waiver to take any steps to make Medicare Advantage the default Medicare option for seniors?

Response (22-24): If confirmed, I will follow the law.

Question 25: Please provide the committee with a full accounting of your financial connections to companies that make and sell drugs or dietary supplements or provide services to the drug or dietary supplements industry, as well as any investments in insurance companies, including the nature and monetary value of each connection from five years ago to the present.

Response: In connection with the nomination process, I filed a 40-page public financial disclosure that provides the public with a full accounting of my financial interests in compliance with the applicable laws for Presidentially Appointed, Senate-Confirmed Positions. In addition, I provided additional financial information in response to the Committee's thorough bipartisan due diligence process. As such, my advisors and I have worked diligently throughout this process to respond to this Committee's inquiries on these topics and to ensure that the public record is accurate and complete regarding my personal finances, including any financial interests or arrangements that I may have in companies that make or sell drugs or dietary supplements. A copy of my financial disclosure report, which has been certified by both the Office of

Government Ethics and the HHS Designated Ethics Officials was promptly forwarded to the Committee by the Office of Government Ethics. In short, I have participated in the same long-standing and thorough diligence process that the Committee has applied to nominees in previous administrations to ensure that the Senate can uphold its constitutional advice and consent duties.

Question 26: Please list all health-related companies that have paid you, either directly or through an entity with which you are affiliated, to promote their products or services in the past 5 years. For each payment, specify how much you have been paid, the dates of payments, and the entity to which the payment was made.

Response: In connection with the nomination process, I filed a 40-page public financial disclosure that provides the public with a full accounting of my financial interests in compliance with the applicable laws for Presidentially Appointed, Senate-Confirmed Positions. In addition, I provided additional financial information in response to the Committee's thorough bipartisan due diligence process. As such, my advisors and I have worked diligently throughout this process to respond to this Committee's inquiries on these topics and to ensure that the public record is accurate and complete regarding my personal finances, including any financial interests or arrangements that I may have in companies that make or sell drugs or dietary supplements. A copy of my financial disclosure report, which has been certified by both the Office of Government Ethics and the HHS Designated Ethics Officials was promptly forwarded to the Committee by the Office of Government Ethics. In short, I have participated in the same long-standing and thorough diligence process that the Committee has applied to nominees in previous administrations to ensure that the Senate can uphold its constitutional advice and consent duties.

a. Do you plan to continue receiving any such payments for future or past promotional services while at CMS?

Response: If confirmed by the Senate to the position of CMS Administrator, I will continue to consult with the agency ethics officials and act in accordance with all applicable laws and regulations governing conflicts of interest.

Question 27: Do you plan to continue posting content that promotes any health company's product or service to your website, YouTube channel, social media page, or any other media platform while serving at CMS?

a. Will you commit to not promoting health-related products or services via any media outlet while at CMS, to avoid a conflict of interest or the appearance thereof?

Response: I take seriously the obligations of CMS Administrator and, if confirmed, I will uphold the oath to faithfully discharge my duties. In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest. As part of that process, I have consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing

conflicts of interest. If confirmed by the Senate to the position of CMS Administrator, I will continue to consult with the agency ethics officials and act in accordance with all applicable laws and regulations governing conflicts of interest.

Question 28: Please list any active media platforms that you own.

a. Do you plan to continue speaking about health-related matters on any media platform you own while serving at CMS?
b. Given that your leadership position at CMS could drive viewers to your platforms in ways that could enrich you, please describe any steps you will take to cease or alter your media appearances on platforms you own.

Response (a-b): In connection with the nomination process, I filed a 40-page public financial disclosure that provides the public with a full accounting of my financial interests in compliance with the applicable laws for Presidentially Appointed, Senate-Confirmed Positions. In addition, I have consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest, consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest. If confirmed to the position of CMS Administrator, I commit to doing whatever I can to ensure that CMS provides Americans with access to superb care, especially Americans who are most vulnerable, our young, our disabled, and our elderly. In so doing, I will consult with the ethics officials at HHS to ensure that my actions in furtherance of this mission are done in accordance with the applicable conflicts of interest laws and regulations.

Question 29: Will you divest or forfeit all vested and unvested restricted stock units and any other form of equity in iHerb before taking office?

Response: As I pledged in my ethics agreement, upon my confirmation, I will resign my position as Advisor to iHerb, forfeit the unvested RSUs in iHerb, and divest vested iHerb RSUs within 90 days of my confirmation. Following these steps, I will no longer have a financial interest or position in the company. In light of these commitments, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified my compliance with the applicable conflict of interest laws and regulations.

Question 30: Do you plan to seek a waiver pursuant to 18 U.S.C. § 208(b) so that you can perform work related to health care companies in which you are invested, while you still own those investments for up to 90 days after taking office?

Response: As I pledged in my ethics agreement, upon confirmation, I will resign as advisor to iHerb, LLC and forfeit my unvested RSUs in in iHerb, LLC. I also will divest my vested RSUs in iHerb, LLC as soon as practicable but not later than 90 days after confirmation. I am committed to upholding the pledges in my ethics agreement to address any conflicts of interest that these ethics officials have identified. In addition, I will act in compliance with the applicable conflict of interest law and governing regulations.

Question 31: Please describe the work of iHerb Oz Partners LLC and the precise relationship between iHerb LLC and iHerb Oz Partners LLC.

Response: As I have previously noted in response to the Committee's thorough bipartisan due diligence process, iHerb Oz Partners LLC is a multi-member LLC that was created as an investment holding company. Although iHerb Oz Partners originally intended to invest in iHerb LLC, it did not do so and has no financial stake in the company. As noted in my ethics agreement, I do not, and have never, had financial interests in iHerb Oz Partners LLC.

Question 32: Please describe in detail the work of each of the following: Oz Works LLC, Zoco Productions LLC, Oz Parents Apartments LLC, Oz Property Holdings LLC, and Oz Media LLC.

a. Your ethics agreement notes: "I will not at any time receive compensation for services that I perform during my Federal appointment." However, during your time at CMS, do you plan to receive compensation for services that you performed for any of these entities before your federal appointment?

Response: In connection with the nomination process, I filed a 40-page public financial disclosure that provides the public with a full accounting of my financial interests, positions and arrangements, including with respect to the LLCs referenced above. In addition, I have consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest, consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest. If confirmed to the position of CMS Administrator, I will consult with the ethics officials at HHS and act in accordance with the applicable conflicts of interest laws and regulations.

Question 33: Please describe your understanding of how the following entities' work relate to the work of CMS: SandboxAQ, Housey Pharma, EKO Health Inc., iHerb, LLC, and Cardiology Partners Co., LP.

Response: As I pledged in my ethics agreement, I will resign my positions with each of the five entities listed above upon my confirmation and I will divest my financial interest in them as soon as practicable, but not later than 90 days after my confirmation. In addition, I agreed for a period of one year after my resignation not to participate personally and substantially in any particular matter involving specific parties in which I know that any of the five entities listed above is a party or represents a party unless I am first authorized to participate, pursuant to 5 C.F.R. §2635.502(d).

Question 34: Will you commit to recuse yourself from all particular matters involving your former clients and employers for at least four years?

Response: In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest. As part of that process, I have consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations.

Question 35: Will you commit to not seeking employment, board membership with, or another form of compensation from any company that you regulated or otherwise interacted with while at CMS, for at least four years after leaving office?

Response: If confirmed as CMS Administrator, I will consult with the agency ethics officials regarding any applicable post-employment restrictions and I will act in compliance with the applicable laws and governing regulations.

Question 36: Will you commit to not lobbying CMS — either as a formal registered lobbyist or informal "shadow lobbyist" — for at least four years after leaving office?

Response: If confirmed as CMS Administrator, I will consult with the agency ethics officials regarding any applicable post-employment restrictions and I will act in compliance with the applicable laws and regulations.

Question 37: What actions have you taken to comply with FTC social media disclosure requirements?

Response: I have always been transparent with the public about my affiliations.

Question 38: If confirmed, will you endorse treatments that have not been shown to be safe and effective by the FDA for reimbursement by Medicare?

Response: If confirmed, I will work with Secretary Kennedy, President Trump, and the professional staff at CMS to ensure all treatments reimbursed by Medicare are reasonable and necessary.

Question 39: If confirmed, will you endorse treatments that have not been shown to be safe and effective by the FDA for reimbursement by Medicare?

Response: If confirmed, I will work with Secretary Kennedy, President Trump, and the professional staff at CMS to ensure all treatments reimbursed by Medicare are reasonable and necessary.

Question 40: Do you now believe that hydroxychloroquine is an effective COVID-19 treatment?

Response: I support researching and providing access to all potential treatments to COVID-19 and other infectious diseases.

Question 41: In 2009, the New York Times ran a story saying that a company you advised and advertised for, Realage.com, administered questionnaires to patients and then sold their identified data to pharmaceutical companies. This included sensitive information and data for over twenty-seven million people. Sharecare, the home-health MA company that you founded, was also subject to a significant data breach of personal health information in 2018.

a. Do you still have any relationship with Realage.com?

   Response: No

b. CMS is part of HHS, which administers HIPAA. Can we trust you to safeguard the medical information of the millions of Medicare and Medicaid beneficiaries better than you did those of realage.com?

   Response: If confirmed, I will abide by all federal laws and regulations related to patient data privacy.

c. Were you aware of the 2018 data breach at Sharecare? If so, did you take any action as a result?

   Response: Sharecare was hacked in the Summer of 2018 and hired outside experts to help conduct a forensic review of over a dozen companies which Sharecare owned. Through that process, the company learned that thousands of records were potentially implicated, but no data was compromised. The Sharecare Board was informed along with the customers in December, 2018 and had no role in addressing hack. The HHS Office of Civil Rights reviewed the Sharecare process and agreed that the company handled the hack correctly.

Question 42: If confirmed as CMS Administrator, would you continue to support implementation, without interruption, of the drug price negotiation program of the IRA?
Question 43: Are you supportive of the $2,000 out-of-pocket cap and the $35 cap on insulin in the IRA?

Response (42-43): The issue of drug pricing is one of great concern to Americans. President Trump has made it clear that he wants to lower drug prices both in terms of what the government pays and what Americans pay. I plan to follow the laws and work with the President and Congress to identify levers to lower prescription drug prices for all Americans.

Question 44: Do you support expanding the number of drugs Medicare negotiates?
Question 45: Will you retain Medicare and Medicaid coverage of anti-obesity medications, such as Ozempic and Wegovy, for weight loss for people with obesity? Will you direct the Medicare

drug price negotiation team at CMS to aggressively negotiate the lowest possible price on Ozempic and Wegovy for Medicare patients, consistent with the law?

Response (44-45): Lowering the cost of prescription drugs for Americans is a top priority of President Trump and his Administration. If confirmed, I plan to follow the law and I look forward to working to lower prescription drug prices for all Americans.

Question 46: Do you support incorporating a ceiling in Medicare drug price negotiations so U.S. patients and taxpayers don't pay more for the same drug as people in countries like France, Germany, and the UK?

Response: Lowering the cost of prescription drugs for Americans is a top priority of President Trump and his Administration. If confirmed, I plan to follow the law and explore other policy options to lower the cost of prescription drugs.

Question 47: Do you support removing lengthy delay periods that prohibit negotiations until a drug has been on the market for nearly a decade or even longer?
Question 48: Do you support extending these already lengthy delay periods that prohibit negotiations until a drug has been on the market for nearly a decade or even longer, yes or no?
Question 49: Do you support expanding access to prices negotiated by Medicare to people with private health insurance?
Question 50: Do you support expanding the orphan drug exemption for drugs approved for more than one rare disease or condition?

Response (47-50): Lowering the cost of prescription drugs for Americans is a top priority of President Trump and his Administration. If confirmed, I plan to follow the law and explore policy options to lower prescription drug prices for all Americans.

Question 51: The IRA provided a mechanism to protect Medicare beneficiaries from vaccines preventable diseases by requiring Medicare drug plans to make vaccines recommended by the Advisory Committee on Immunization Practices free for enrollees. The IRA requirement guarantees nearly 53 million Medicare Part D beneficiaries access to free vaccines. Where do you stand on preserving this benefit, particularly at a time when vaccine policy has become politicized?

Response: If confirmed, I will follow the law.

Question 52: When you go to buy a car or take out a mortgage when you buy a house, the costs are clearly spelled out for everyone. But when you purchase medicine, the pharmaceutical companies and the PBM middle-players keep that information secret. Consumers and competitors cannot make informed choices. What will you do to improve transparency in the system?
Question 53: Are you supportive of the FTC's lawsuit against the three largest PBMs?
Question 54: Medicare Advantage and Part D plans frequently use "preferred cost-sharing pharmacies." The underlying statutes require that any such preference shall not result in an increase in payments. However, the FTC's recent interim report on PBMs demonstrates that

UnitedHealthcare, among other health plans, pays its preferred pharmacies, including Walgreens and its own mail-order pharmacy, substantially more than non-preferred pharmacies, such as Costco and independent pharmacies. Will you direct CMS to examine the prevalence of and enforce the prohibition against plans' increased payments to preferred pharmacies?

Question 55: Do you support updating the conditions of participation in Medicare Part D to prohibit anticompetitive practices, including kickbacks, rebates, and exclusive contracts?

a. Do you support repealing the safe harbor to the federal anti-kickback statute, which enables pharmaceutical middlemen such as PBMs and group purchasing organizations to accept kickbacks and rebates from drug manufacturers that would otherwise be a felony offense?

Question 56: The Medicare Modernization Act requires CMS to define "reasonable and relevant" terms and conditions for contracts between Part D plans and pharmacies. CMS has never defined these terms. Will you commit to doing so in a way that ensures independent pharmacy access for beneficiaries?

Question 57: Do you support comprehensive PBM reform, including banning spread pricing in Medicare managed care programs and requiring PBMs to reimburse pharmacies according to fair benchmarks that account for their costs?

Response (52-57): I believe increased transparency in PBM practices would help CMS better examine what is happening in the prescription drug market. If confirmed, I look forward to working with you and stakeholders to address these issues.

Question 58: If confirmed, would you finalize CMS' 2024 proposed rule to cover obesity medications, such as Ozempic, under Medicare & Medicaid?

Response: If confirmed, I will follow the law and work to ensure patients and providers are empowered to make it easier to do the right thing when it comes to their health and work with Secretary Kennedy to ensure that CMS can make Americans healthy again.

Question 59: The Bayh-Dole Act, codified at 35 U.S.C. § 203, gives the federal government the right to grant licenses to "responsible applicant[s]" for patented inventions developed with federal funds if those inventions are not "available to the public on reasonable terms," which includes price. Do you support the use of march-in rights to help lower drug costs for Americans?

a. If so, do you believe that a drug's price is an appropriate factor to consider in determining if the government should exercise march-in rights?

Response: If confirmed, I look forward to working with partner federal agencies and Congress to learn more about this issue.

Question 60: Do you believe that all low-income people, and people with disabilities, should be able to access Medicaid? By low-income, I mean family income of up to 138% of the Federal Poverty Rate, the Medicaid eligibility threshold established under the Affordable Care Act.

Response: Medicaid eligibility categories are set by Congress. If confirmed, I would partner with states to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

Question 61: In some states, like Texas, the bar for qualifying for Medicaid is exceptionally high. For example, a parent in a two-person household making $2,500 per month makes too much money to qualify for Medicaid. Do you think this is acceptable?

Response: If confirmed, I would work to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

Question 62: The HHS Office of the General Counsel issued an advisory opinion about the disutility of work requirements – which seeks to deprive extremely low-income people of health care at great administrative waste to the federal government. Will you commit to preventing states from enacting this harmful, wasteful policy?

Response: **Community engagement empowers individuals and fosters a sense of purpose and dignity. I look forward to empowering states with the flexibility to tailor their Medicaid program in ways that best serve their populations while efficiently using taxpayer dollars, fostering personal responsibility, and promoting health outcomes.**

Question 63: Many of your colleagues have called for limiting federal support to the Medicaid program, which would throw state budgets into disarray and result in substantial coverage losses. Do you believe federal Medicaid funding to states should be capped? If so, do you believe that not all low-income people should have access to health insurance?

Response: Medicaid funding is determined by Congress. If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.

Question 64: Medicaid is the largest payer of Opioid Use Disorder treatment in the nation. How would you support expansion of medications for opioid use disorder?
Question 65: In recent months, CMS has approved a number of state 1115 waivers to facilitate access to Medication for Opioid Use Disorder (MOUD) for an extremely vulnerable population – incarcerated individuals re-entering society. Formerly incarcerated individuals are up to 129 times more likely to die of overdose in their first two weeks after release. However, evidence shows that providing MOUD reduces post-release overdose deaths by helping individuals maintain recovery during this critical transition period. There has been bipartisan support for the approval for these waivers. If confirmed, would you expeditiously review and approve Section 1115 waiver applications that would expand access to this life-saving medication?

a. What specific steps would you take to ensure these applications receive timely consideration?

Response (64-65): **If confirmed, I will work to improve access to the most appropriate care for individuals who need substance use disorder services. It is my understanding that section 1115 waiver applications are reviewed on a rolling basis, and if confirmed, I look forward to working with states to foster access to affordable, high quality mental and behavioral health care coverage that best meets the needs of individuals and their families.**

Question 66: Do you believe it is important for all children and adults on Medicaid and Medicare to have access to lifesaving vaccines? Will you commit to ensuring that vaccines remain covered without cost-sharing?

Response: **Both Medicaid and Medicare Part D plans generally cover recommended vaccines with no cost sharing. If confirmed, I will follow the law.**

Question 67: What are your primary concerns with the Medicaid program? What are your top priorities for improving it?

Response: **If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.**

Question 68: The Biden Administration finalized rules to increase oversight of private Medicaid managed care organizations. Are you supportive of these rules? If not, what would you propose instead?

Response: **Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries while we work to modernize our tools to reduce fraud, waste and abuse.**

Question 69: Do you support allowing flexibilities in the Medicaid program to cover social needs that contribute to poor health outcomes, such as housing support services, nutrition services, and home environment improvements (air ventilation, refrigeration, accessibility modifications)? Do you also support recent expansions to allow substance use coverage under Medicaid pre-release for people transitioning out of incarceration?

Response: **If confirmed, I will review all 1115 waivers to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries.**

Question 70: Over 40 states have expanded Medicaid under the Affordable Care Act, significantly reducing uninsured rates among low-income individuals. Do you believe the remaining 10 states should expand Medicaid, and if not, how would you address the coverage gap for low-income adults in non-expansion states?

Response: **If confirmed, I will ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.**

Question 71: Are you supportive of using impoundment to cut or withhold federal spending, including for Medicaid?

Response: **If confirmed, I will follow the law.**

Question 72: Do you commit to following 50 years of precedent and inviting full public notice and comment to any and all changes to the Medicaid program?

Response: **If confirmed, I will follow the law.**

Question 73: Do you support repealing the ACA?

Response: **If confirmed, I will follow the law and ensure Americans have access to affordable, high-quality coverage through the programs CMS administers, including the ACA.**

Question 74: The ACA includes several protections for individuals to safeguard against abuse by private health insurers. Will you commit that you will not seek to unravel or delay any of these protections through the rulemaking process or by issuing new agency guidance? Please provide answers with respect to the specific protections listed below:

a. Provisions that prevent insurers from refusing coverage to patients with preexisting conditions;
b. Provisions that prevent insurers from charging exorbitant out of pocket costs;
c. Provisions that prevent insurers from charging women more for coverage than men;
d. Provisions that prohibit insurers from establishing annual or lifetime limits on coverage;
e. Provisions that prohibit insurers from rescinding coverage for the seriously ill;
f. Provisions that require certain insurers to provide preventive health care with no cost-sharing;
g. Provisions that guarantee insurance renewal for patients who pay their premiums in full; and
h. Provisions that expand insurance coverage of mental health and substance use disorder services.

Question 75: Are you supportive of the ACA's protections for individuals with pre-existing conditions? Do you believe private insurance companies should be required to cover individuals with pre-existing conditions without raising their premiums?

Response (74-75): **If confirmed, I will follow the law and ensure Americans, including those with pre-existing conditions, have access to affordable, high-quality coverage through programs CMS administers.**

Question 76: During his first term, President Trump expanded the availability of short-term health plans, also known as "junk plans." These plans are not required to comply with protections under the ACA, allowing private health insurers to deny coverage based on pre-existing conditions and skirt requirements on essential benefits. The Biden Administration reversed this damaging policy in 2024.

a. If confirmed as CMS Administrator, would you expand the availability of short-term health plans?

Response: **If confirmed, I will work within CMS and across the Executive Branch, to improve the health insurance system so that is more affordable and accessible, and allows individuals to choose the type of insurance coverage that best meets their needs.**

Question 77: Are you supportive of the ACA's advanced premium tax credit? If not, what changes would you make to it?
Question 78: Do you support expanding Medicaid coverage through the ACA?
Question 79: How would you address gaps in coverage for low-income individuals living in states that have not expanded Medicaid?

Response (77-79): **If confirmed I will ensure Americans have access to affordable, high-quality coverage through the programs CMS administers, including the ACA.**

Question 80: Do you commit to following 50 years of precedent and inviting full public notice and comment to any and all changes to the ACA?

Response: I**f confirmed, I will follow the law.**

Question 81: The Biden Administration challenged Idaho's abortion ban under the Emergency Medical Treatment and Labor Act (EMTALA), arguing that Idaho's ban is preempted to the extent that it restricts providers from providing stabilizing care that is federally required under EMTALA. Project 2025 directs HHS to take several steps to limit EMTALA's protections, including but not limited to withdrawing the Biden Administration's July 2022 guidance on EMTALA's preemption of state-level abortion bans, ending investigations into alleged EMTALA violations, and eliminating existing injunctions and withdrawing or settling existing lawsuits under EMTALA.

a. If confirmed as Administrator of CMS, would you ensure access to emergency abortion under EMTALA, including continuing the current Department of Justice (DOJ) lawsuits, and to help enforce the rights of women under this life-saving law?

Response: If confirmed, I will follow the law.

Question 82: In August 2022, the Biden Administration encouraged states to apply for Medicaid funding under Section 1115 demonstration authority to expand access to reproductive care. Project 2025 directs the HHS Secretary to withdraw that guidance and any Section 1115 waivers issued thereunder.

a. If confirmed as Administrator of CMS, would you commit to protecting states' right to use Section 1115 waivers for programs to help women access reproductive care?
b. Will you commit to encouraging CMS to approve such waivers?

Response: If confirmed, I will follow the law and President Trump's Executive Order on Enforcing the Hyde Amendment[4] to protect taxpayers from funding or promoting abortion.

Question 83: Project 2025 directs HHS to issue guidance or regulations stating that states can exclude Planned Parenthood health centers and other providers of abortions from their state Medicaid plans.

a. If confirmed as Administrator of CMS, would you issue guidance that could lead to the defunding of Planned Parenthood and other providers of abortions?

Response: If confirmed, I will follow the law and President Trump's Executive Order on Enforcing the Hyde Amendment[4] to protect taxpayers from funding or promoting abortion.

Question 84: Project 2025 directs CMS to "resolve pending Section 1115 waivers from Idaho, South Carolina, and Tennessee, which…are seeking…to prohibit abortion providers from participating in state-run Medicaid programs." Additionally, Texas has a pending waiver seeking to exclude abortion providers from the Healthy Texas Women family planning program.

a. If confirmed as Administrator of CMS, would you commit to direct HHS to deny states from excluding abortion providers from participating in Medicaid programs as seen in these waivers?

Response: If confirmed, I will follow the law and President Trump's Executive Order on Enforcing the Hyde Amendment[4] to protect taxpayers from funding or promoting abortion.

Question 85: Project 2025 directs CMS to withdraw up to 10 percent of Medicaid funds from states that require private health insurance plans to cover abortion care or that terminate state contracts with pharmacies that do not carry abortion medication.

a. Do you commit to oppose any such attempts to withdraw Medicaid funds from such states?

Response: If confirmed, I will follow the law and President Trump's Executive Order on Enforcing the Hyde Amendment[4] to protect taxpayers from funding or promoting abortion. I will also abide by Federal conscience protection laws.

Question 86: In December 2011, you said you support women's access to a range of contraception, including forms of Long-Acting Reversible Contraception (LARC) like Intrauterine devices (IUDs).

a. Do you support women's access to a full range of contraception, including LARCs and emergency contraception?

b. How would you use CMS authorities to expand women's access to, and coverage of, FDA-approved forms of contraception?

Response (a-b): If confirmed, I will follow the law.

Question 87: Planned Parenthood health centers help women across the country access birth control methods. In 2015, you wrote in your column in the Idaho Statesman, "If You Want To Find The Best Birth Control For You And Yours, Go To The Planned Parenthood Website (Plannedparenthood.Org) And Talk To Your Doctor."

a. Do you still support a woman's right to seek out the best birth control treatment option at Planned Parenthood health centers or other abortion providers?

Response: If confirmed, I will follow President Trump's Executive Order on Enforcing the Hyde Amendment[4] to protect taxpayers from funding or promoting abortion.

Question 88: In December 2021, you said that you are "pro-life," except in three situations: rape, incest and cases in which the woman's health is at risk.

a. Do you still support exceptions to abortion bans in these three situations?
b. Do you believe women should have access to abortion care outside of these three situations?

Response: I am unequivocally pro-life and aligned with President Trump on supporting exceptions in the case of rape, incest, and life of the mother.

Question 89: In May 2022, you said that abortion at any stage of pregnancy is "still murder" because you believe that life begins at conception. This also could indicate a view that a fetus or embryo should be considered a "person" under the U.S. Constitution, a view known as fetal personhood. This concept could be used to outlaw not only abortion but also fertility treatments such as in vitro fertilization (IVF). Indeed, over a dozen states have Wrongful Death and/or Fetal Personhood laws or statutes that could encompass frozen embryos.

a. Do you still stand by the statement that abortion at any stage of pregnancy is "still murder"?
b. Do you believe that a fetus or embryo should be considered a "person" under the U.S. Constitution and have the same rights as a person who is currently alive?
c. Do you believe that health care, like IVF, which when performed in accordance with widely accepted and evidence-based medical standards of care involves the creation, cryopreservation, and sometimes the discarding of embryos is "murder"?
d. Would you support access to IVF if appointed Administrator of CMS?

Response: I am unequivocally pro-life and support access to IVF. If confirmed, I will follow the law and implement any directives that the President may make in connection with his Executive Order "Expanding Access to IVF."

Question 90: In October 2022, you said that a woman's decision to have an abortion should be left to "women, doctors, [and] local political leaders."

a. Do you still hold this view? Which political leaders do you believe should have a say in women's decisions about abortions?
b. More broadly, who do you believe should be involved in a women's reproductive choice and why?

Response: I am unequivocally pro-life. If confirmed, I will follow the law.

Question 91: Are you aware of the analysis conducted by experts at the University of Pennsylvania revealing that the new nursing home standards would save approximately 13,000 lives per year?

Question 92: If confirmed, would you commit to implementing and enforcing the CMS staffing rule on its current timeline?

Question 93: Nursing home staffing is directly linked to the quality of care residents receive. A report prepared by my staff in November 2023 revealed that nursing homes with higher staffing levels have higher overall quality ratings, lower levels of patient abuse, and higher quality care. In addition, an analysis by researchers at the University of Pennsylvania finds that CMS' final rule would save approximately 13,000 lives per year.

a. Do you agree with the broad consensus from experts that there are benefits to increasing staff levels and reducing workforce turnover in nursing homes?

Question 94: The for-profit nursing home industry is fighting to overturn CMS' final rule on nursing home staffing, and the industry is reportedly hopeful that President Trump will rescind the rule or that the Republican Congress will overturn it legislatively.

a. If confirmed, would you commit to oppose any and all efforts to repeal the rule?
b. If the rule is repealed, what would you do to mitigate the catastrophic health impacts caused by low staffing levels and high staff turnover in nursing homes?

Response (91-94): If confirmed, I will work within CMS to ensure nursing home residents receive safe, high-quality care.

Question 95: If confirmed, would improving quality of care in nursing homes be a priority for CMS? How would you go about tackling this issue? Would improving conditions for nursing home staff and reducing staff turnover be part of your strategy?

Response: N**ursing home residents are some of the most vulnerable people in our society, and, if I am confirmed, ensuring they receive safe, high-quality care will be a top priority of CMS.**

Question 96: Private equity ownership of health care facilities, including nursing homes, has resulted in problems for taxpayers and patients.

a. Do you believe that CMS has the tools it needs to address the problems caused by private equity in health care?
b. If confirmed, would you use all tools CMS has available to it to mitigate the negative impact of private equity in health care, including enforcing quality of care standards at nursing homes, hospitals, and other health care facilities?

Response (a-b): **If confirmed, I will make it a priority to address high quality care in nursing homes and take appropriate enforcement actions on nursing homes that are not in compliance with the health and safety standards. I will also work to provide Medicare beneficiaries with information to make informed decisions when it comes to their health care decisions to make sure that seniors and their families have the information they need to choose quality care.**

Question 97: Extensive research shows that health care consolidation and privatization of public programs are significant factors causing out-of-control health care costs and declining care quality. How do you propose to address this consolidation and privatization?

Response: If confirmed, I look forward to taking any steps necessary to ensure that patients in programs administered by CMS can get the care they need.

Question 98: Would you support legislation that structurally separates payers (e.g., insurers, pharmacy benefit managers (PBMs), and wholesale drug distributors) from providers (e.g., medical practices and pharmacies), including the Patients Before Monopolies Act, which I introduced with Senator Hawley?

Response: The role played by PBMs in prescription drug pricing and pharmacy reimbursement is an issue of concern to President Trump, myself, and to many Americans. I believe increased transparency in PBM practices would help CMS better examine what is happening in the drug market. If confirmed, I look forward to working with Congress on this issue.

Question 99: To comply with the federal medical loss ratio (MLR) requirement, health insurers must spend at least 85% of premium dollars on medical care. However, recent state audits, federal watchdog reports, and media investigations show that insurers – including those administering Medicare Advantage and Medicaid managed care plans – waste public money by skirting this requirement, often through subcontracting arrangements with PBMs and others. How would you prevent such regulatory gaming?

Response: If confirmed, I look forward to working with you on this issue.

Question 100: Would you support legislation that caps and standardizes healthcare prices to undo corporations' incentives to consolidate, overcharge, and withhold care?

Response: If confirmed, I look forward to working with you to understand this issue.

Question 101: Lax enforcement of state prohibitions on the corporate practice of medicine (CPOM) has further greased the wheels for the corporatization of health care. Do you support state efforts to strengthen corporate practice of medicine laws?

Response: If confirmed, I will work in partnership with states to help advance their goals to foster an affordable, accessible, high quality health care system that best meets the needs of individuals and their families.

Question 102: What policies would you propose to ensure truly independent physician practices remain viable?
Question 103: Do you believe site neutral payment reform would help combat increasing hospital consolidation?

Response (102-103): If confirmed, I will work with my colleagues at CMS, Secretary Kennedy, Congress, and stakeholders to evaluate the appropriateness of payment rates for physicians and hospitals to ensure access, while controlling costs.

Question 104: Do you commit to working with Secretary Kennedy and the Administration's antitrust enforcers to promote competition in the health care industry, including by monitoring the impact of serial roll-ups on the cost and quality of health care?

Response: If confirmed, I want to empower beneficiaries with better tools and more transparency, so the American people can better navigate their health to achieve better health outcomes.

Question 105: Chronic kidney disease is an epidemic, affecting 36 million — or one in seven — American adults. Despite Medicare alone spending $130 billion annually on patients with this disease, U.S. outcomes are worse than in other countries. Just two for-profit dialysis providers, DaVita Kidney Care and Fresenius Medical Care, control more than 80% of the U.S. market. This duopoly exacerbates predatory pricing and reduces care quality, as measured by hospitalization and mortality rates. If confirmed, will you commit to prioritize addressing the chronic kidney disease crisis, including by directing CMS to create new clinical practice standards that define dialysis adequacy according to current evidence, enforcing CMS requirements that patients be informed of all dialysis options and where to find them, and increasing staffing ratio requirements for dialysis clinics?

Response: If confirmed, I will work to ensure that Medicare meets the needs of beneficiaries, empowers beneficiaries with better tools and more transparency to better navigate their health, and furthers the goal of Making America Healthy Again.

Question 106: What is your opinion on the role the RUC plays in advising physician fee schedules? How, if at all, would you support reforming the RUC?
Question 107: Do you support reforms to the Medicare physician fee schedule, including resolving disparities between primary and specialty care services?
Question 108: Do you support replacing the American Medical Association's Relative Value Scale (RVU) Update Committee with an independent third party not dominated by specialists?

Response (106-108): If confirmed, I look forward to working with Congress to ensure the physician fee schedule promotes access to high-quality care in a sustainable manner.

Question 109: Do you support increasing Medicare investment in primary care residency slots and allocating them to underserved areas to meet patient demand?

Response: If confirmed, I look forward to exploring ways to ensure seniors have access to primary care when and where they need it.

Question 110: What mechanisms would you implement to ensure that MA plans comply with reporting requirements for encounter data, including denied claims and prior authorizations?

Response: I believe Americans should be empowered with better tools and more transparency so they may better navigate their health. If confirmed, I look forward to exploring ways to make sure that Medicare Advantage provides access to better health outcomes and quality for seniors.

Question 111: Given the increasing vertical consolidation in Medicare Advantage, where plan sponsors often own or are financially tied to provider entities, how do you plan to enhance transparency around ownership and control? Would you require detailed reporting on ownership structures, related-party contracts, and incentive arrangements to ensure proper oversight and evaluate the impact of these relationships on cost, quality, and access for beneficiaries?
Question 112: Medicare Advantage plans are increasingly owned by private equity firms and health systems, raising concerns about transparency and accountability in plan operations. Would you direct CMS to develop a publicly accessible database detailing ownership structures of MA plans, including Taxpayer identification Numbers (TINs) and relationships to parent organizations, to enable better oversight and research into the implications of these ownership arrangements?

Response (111-112): I believe in transparency, accountability, and access, and that applies to the Medicare Advantage program. I look forward to exploring ways to make sure that Medicare Advantage Organizations provide access to quality healthcare to seniors.

Question 113: Researchers face a three-year lag in MA encounter data compared to traditional Medicare data. Will you commit to reducing this lag to improve timely research and policymaking?
Question 114: The new data access policies requiring the use of the Virtual Research Data Center (VRDC) may increase costs and limit access. How would you ensure equitable and affordable access to MA data for researchers?
Question 115: Current MA data lacks accurate race and ethnicity information, limiting transparency in health equity analysis. How would you improve demographic data collection to better assess equity in MA plan performance?

Response (113-115): I believe in transparency, accountability, and access, and that applies to the Medicare Advantage program. If confirmed, I look forward to evaluating ongoing processes and policies to assess the program to ensure it meets these goals.

Question 116: Would you require MA plans to report whether services were delivered in-network or out-of-network to better understand access and utilization patterns?

Response: I believe Americans should be empowered with better tools and more transparency so they may better navigate their health. If confirmed, I look forward to exploring ways to make sure that Medicare Advantage provides access to better health outcomes and quality for seniors.

Question 117: Brokers play a significant role in MA enrollment, but their activities and payments are not transparent. Would you direct CMS to require reporting on broker involvement and compensation to ensure accountability?

Response: If confirmed, I look forward to exploring ways to make sure that America's seniors are equipped with the information they need to make the best healthcare decisions.

Question 118: The Government Accountability Office recently noted that there has been a lack of hospitals complying with hospital price transparency rules and that CMS has lacked enforcement of the rules. A recent report even found that more than one-third of 100 hospitals reviewed did not properly post machine-readable pricing data. How do you plan to have CMS improve enforcement of these rules?
Question 119: Research shows hospitals continue to ignore or thwart price transparency requirements enacted during the first Trump administration to help consumers make informed choices about their care. How do you plan to increase CMS' enforcement of these requirements?

Response (118-119): President Trump implemented historic price transparency requirements on hospitals and health plans to ensure consumers have the pricing information they need to make the best care decisions for themselves and their families. If confirmed, I will implement the Executive Order entitled "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" and will take all necessary steps to improve existing price transparency requirements; increase enforcement of price transparency requirements; and identify opportunities to further empower patients with meaningful price information.

Question 120: There have been ongoing concerns regarding the enforcement of post-2015 site-neutral payment requirements in Medicare. Reports suggest that compliance has been uneven, possibly due to resource constraints or gaps in enforcement authority. How would you address these challenges, and what steps would you take to ensure consistent enforcement of site-neutral payment policies moving forward?

Response: **I will follow the law. If confirmed, I look forward to working with Congress to evaluate the appropriateness of all Medicare payment rates.**

Question 121: Nonpartisan research has shown that Medicare beneficiaries have limited knowledge about important aspects of private Medicare plans before enrolling. This includes information on companies' tendencies to delay and deny care; the quality of supplemental benefits offered by private companies' and up-to-date information on which doctors and

hospitals are included in insurance networks. What would you do to improve transparency for beneficiaries seeking to enroll in Medicare Advantage?

Response: If confirmed, I am committed to providing all of America's seniors with transparency when it comes to health care. I look forward to exploring ways to make sure that seniors and their families have the information they need to receive quality care.

Question 122: How will you protect Medicaid beneficiaries' access to care at Community Health Centers, as health centers ensure taxpayer dollars are used highly efficiently?
Question 123: Will you commit to working with me to ensure CMS reimburses Community Health Centers in a manner that not only protects but also expands access to efficient and effective primary care?

Response (122-123): If confirmed, I will work to foster better health outcomes and quality care for all Americans.

Question 124: Will you commit to paying the IRS the full amount of taxes that the Senate Finance Committee staff found that you did not pay because of your questionable tax avoidance tactics?

Response: Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. My advisors and I have provided copious supporting materials to respond to questions from members of the Committee regarding this question. These responsive materials demonstrate that I followed the applicable law. I will continue to follow the law and pay all appropriate taxes.

Question 125: Will you commit to making your tax filings from the last five years public, with redactions to protect confidential or sensitive personal information, in advance of the Senate Finance Committee's vote on your nomination?

Response: As evidenced by the tax filings and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process, I have participated in the same long-standing process that the Committee has applied to nominees in previous administrations to ensure that the Senate can uphold its constitutional advice and consent duties.

Question 126: Will you commit to voluntarily submitting to an IRS audit of your previous three years of tax filings and all tax filings during your time as Administrator if you are confirmed?

Response: As evidenced by the tax filings and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process, I have participated in the same long-standing process that the Committee has applied to nominees in previous administrations to ensure that the Senate can uphold its constitutional advice and consent duties.

Question 127: Did you materially participate in the activities of Oz Property Holdings, LLC for the years 2021, 2022, and 2023?

a. Please describe your role at Oz Property Holdings, LLC in relation to the chain of command.
b. Please describe your involvement in day-to-day decision-making at Oz Property Holdings, LLC.

Response (a-b): Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. My advisors and I have provided copious supporting materials to respond to questions from members of the Committee regarding this question. These responsive materials demonstrate that I followed the applicable law. I will continue to follow the law and pay all appropriate taxes.

Question 128: Why did you describe yourself as both a "limited partner" in Oz Property Holdings and a material participant in the activities of Oz Property Holdings on the same tax returns?

Response: Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. My advisors and I have provided copious supporting materials to respond to questions from members of the Committee regarding this question. These responsive materials demonstrate that I followed the applicable law. I will continue to follow the law and pay all appropriate taxes.

Question 129: Do you believe that Americans have the right to refuse to pay their Medicare taxes as required by federal law, including as defined by rulings from the IRS and Tax Court?

Response: Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. My advisors and I have provided copious supporting materials to respond to questions from members of the Committee regarding this question. These responsive materials demonstrate that I followed the applicable law. I will continue to follow the law and pay all appropriate taxes.

Question 130: The majority of hospital inpatient and emergency department patients with firearm injuries are covered by Medicaid, Medicare, or other public coverage. Experts anticipate that cuts to Medicaid or Medicare would require hospitals to shift the costs of providing uninsured patients with emergency care to the broader population. How do you anticipate that cuts to Medicaid or Medicare would impact hospital costs for the broader population?

Response: If confirmed, I will work to ensure that the Medicaid and Medicare programs are well administered, effective, and available for the most vulnerable beneficiaries, while also supporting and promoting innovative new approaches to care delivery.

Questions for the Record submitted to Mehmet Oz, MD. from Senator Wyden.

Committee Requests on Administrative Actions

1. It is the position of the U.S. Government that you should be paying Medicare and Social Security taxes on millions of your earnings, and the Tax Court has consistently ruled in favor of the U.S. Government on this particular issue. Yet, you have dodged roughly $440,000 in Medicare and Social Security taxes in the last three years, worsening the financial outlook for the Medicare Part A Trust Fund.

   During a meeting with Senate Finance Committee staff on Friday, March 14, when pressed, you asserted that you would not correct this issue and pay these taxes just as hard-working Americans do out of every paycheck. Please affirm this in writing.

   Response: Every American has a responsibility to follow the law and pay the taxes that he or she owes. I believe that I have done so, as evidenced by the responses and back up documentation that I have already submitted during the Committee's thorough bipartisan due diligence process. My advisors and I have provided copious supporting materials to respond to questions from members of the Committee regarding this question. These responsive materials demonstrate that I followed the applicable law. I will continue to follow the law and pay all appropriate taxes.

2. How will you ensure CMS has adequate staffing to undertake its important mandates?
3. What are your views on the hollowing out of a crucial agency that is responsible for the health and wellbeing of over 160 million Americans?
4. In a bipartisan briefing for Senate Leadership and Committee staff on Friday, March 7, HHS leadership indicated that any request to reinstate probationary employees deemed "mission critical" would be approved on an ongoing basis. As of the briefing, HHS reported 220 probationary employees or 3% of the CMS workforce was fired. Where you identify gaps in CMS resources and staffing, will you seek approval from HHS leadership to reinstate fired employees?
   a. In accordance with a court order, reports suggest CMS is beginning to reinstate fired probationary employees and then directly place those employees on paid administrative leave. Do you intend to reinstate fired probationary employees only to place them on administrative leave?
5. Please provide a list of staff who were laid off or put on administrative leave and the number of remaining employees at CMS's:
   a. Center for Program Integrity (CPI);
   b. Center for Consumer Information and Insurance Oversight (CCIIO);
   c. Center for Clinical Quality and Standards (CCSQ);

d. Center for Medicare & Medicaid Innovation (CMMI);
e. Center for Medicaid & CHIP Services (CMCS);
f. Center for Medicare (CM);
    i. Medicare Drug Price Negotiation Group; and
g. All other Offices supporting CMS and the Office of the Administrator

Response (2-5): If confirmed, I will follow the President's and Secretary's guidance and ensure CMS serves the American people at the highest level and most efficiently.

6. Can you ensure an adequate and detailed written response is provided to all questions included in the letter sent by Ranking Member Wyden and Senator King on March 5, 2024 concerning mass lay-offs across CMS?
    a. Please provide a date by which we can expect to receive a response.

Response: If confirmed, I look forward to reviewing the letter.

7. If confirmed as CMS Administrator, do you intend to fire additional CMS employees?
    a. If yes, what specific staffing reductions will you pursue and in which Centers and Offices within CMS?

Response: I will follow the President and Secretary's guidance and ensure CMS serves the American people at the highest level and most efficiently.

8. Elon Musk has been given access to sensitive data across the federal government, potentially putting that data at risk for improper public disclosure. What steps will you take to ensure that Musk or other staff associated with the Dept. of Government Efficiency (DOGE) do not access data that they should not have access to?
    a. What measures will you put in place to ensure personal data about enrollees in CMS programs (e.g., Medicare, Medicaid, the Affordable Care Act) are not put at risk of public disclosure?

Response: If confirmed, I will work to ensure appropriate data security measures are being followed to protect all beneficiary information.

9. During your confirmation hearing on Friday, March 14, you indicated you have had no interactions with DOGE officials whatsoever. Please affirm this in writing.

Response: As I stated in my hearing, my understanding of current DOGE activities has come from publicly available news reports.

10. On January 31, 2025, Leader Schumer and Ranking Member Wyden wrote to HHS requesting answers on the break-down of Medicaid payment portals. Can you ensure an adequate and detailed written response is provided for all questions included in the letter?
    a. Please provide a date by which we can expect to receive a written response.
11. On February 7, 2025, Ranking Members Wyden, Neal, and Pallone wrote to HHS and CMS with detailed questions on reported access by DOGE to CMS payment systems.

Can you ensure an adequate and detailed written response is provided for all questions included in the letter and that Committee staff, including our member offices, receive a briefing on this issue?

a. Please provide a date by which we can expect to receive a written response.
b. Please provide a date by which we can expect to receive the requested briefing.

12. On February 21, 2025, Senate Democrats wrote to HHS expressing alarm at unilateral lay-offs of 5,000+ civil servants, including CMS employees. Can you ensure we receive an adequate and detailed written response for all questions included in the letter?
    a. Can you ensure all members who signed this letter receive a briefing on this issue? Please provide the date by which the letter's signers can expect to receive the requested briefing.
13. Can you ensure all Technical Assistance (TA) requests currently submitted by Finance Committee Democrats are delivered by April 16, 2025?

Response (10-13): If confirmed, I look forward to working with HHS and CMS staff to provide a response.

14. How do you plan to implement the March 3, 2025 HHS policy statement that would reduce notice and comment rulemaking on federal policies and agency action?
    a. How do you intend to apply this policy statement to rules implementing Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA)?
    b. Will you commit to ensuring that the public and stakeholders impacted by the CMS programs you administer will be able to participate in a transparent notice and comment process as they have for 54 years?

Response: I would like to see CMS do a better job engaging the American people on Agency actions, in line with the HHS policy statement.

Medicare Advantage

15. Do you support competition in the Medicare program, including between private Medicare Advantage (MA) plans and Traditional Medicare?
16. Do you believe Medicare beneficiaries should be able to choose the coverage that is right for them?
17. Do you believe Medicare coverage choices–both MA and Traditional Medicare–should be transparent to beneficiaries so that they can make informed enrollment decisions?

Response (15-17): Seniors deserve to have choices for accessible, high-quality care. If confirmed, I will work to ensure that both traditional Medicare and Medicare Advantage are well administered, effective, and available for eligible beneficiaries.

18. Following a 2022 report by Senate Finance Committee staff identifying deceptive marketing tactics that push seniors and people with disabilities into MA plans without their consent, the Biden-Harris Administration advanced a series of marketing reforms in the MA program. Through rulemaking, CMS finalized policies to strengthen oversight of

MA advertisements, rein in confusing television ads, and tighten guardrails related to broker education, among other provisions. Will you commit to preserving the suite of MA marketing reforms advanced by the Biden-Harris Administration which are intended to protect beneficiaries from abusive and confusing marketing tactics?

a. If no, which specific policies do you intend to roll back and why?

Response: If confirmed, I look forward to exploring ways to make sure that America's seniors are equipped with the information they need to make the best healthcare decisions.

19. In the Contract Year (CY) 2026 MA and Part D proposed rule, CMS included policies to improve access to behavioral health services for MA enrollees. Will you commit to applying a limit of cost sharing no greater than Traditional Medicare to the behavioral health service categories? Specifically, will you commit to the following:
    a. 20% coinsurance or an actuarially equivalent copayment limit for mental health specialty services, psychiatric services, partial hospitalization/intensive outpatient services, and outpatient substance abuse services (current standard: 30% to 50% coinsurance or actuarially equivalent copayment, based on the plan's maximum out-of-pocket (MOOP) type).
    b. Zero cost sharing for opioid treatment program services (current standard: 50% coinsurance or actuarially equivalent copayment for all MOOP types).
    c. 100% of estimated Medicare Fee-For-Service (FFS) cost sharing for inpatient hospital psychiatric services (current standard: 100% to 125% of estimated Medicare FFS cost sharing, based on the plan's MOOP type).

Response: If confirmed, I will work to foster affordable, accessible, high quality mental and behavioral health care that best meets the needs of individuals.

20. In the Contract Year (CY) 2026 MA and Part D proposed rule, CMS included policies to improve transparency for provider directories. Will you commit to finalizing requiring MA organizations to make provider directory data available to CMS to populate MPF? Specifically, will you commit to the following:
    a. Requiring that MA organizations attest to accurate provider directory data, make provider data available to CMS to populate MPF, and update the data accessed by MPF no later than 30 days after being notified of a change in provider information; and
    b. Providing technical guidance for plans to meet data compliance and quality checks so as to ensure the information in provider directories on Medicare Plan Finder is accurate.

Response: If confirmed, I look forward to exploring ways to ensure that seniors are equipped with the information they need to access high quality healthcare.

21. In the Contract Year (CY) 2026 MA and Part D proposed rule, CMS included policies addressing agent and broker requirements. Will you commit to requiring agents and brokers to discuss an individual's potential eligibility for the Low-Income Subsidy and Medicare Savings Programs and the potential impact of MA enrollment on future

Medigap guaranteed issue rights, as well as where an individual might access additional information about these programs?

Response: If confirmed, I look forward to exploring ways to make sure that America's seniors are equipped with the information they need to make the best healthcare decisions.

22. In 2020, you proposed "Medicare Advantage for All." How does increased privatization of the health care system square with Trump and RFK Jr.'s desire to curb the "illness industrial complex" and corporate influence in health care?

Response: Seniors deserve to have choices for accessible, high-quality care. If confirmed, I will work to ensure that both traditional Medicare and Medicare Advantage are well administered, effective, and available for eligible beneficiaries.

23. Trump's Project 2025 plan calls for making Medicare Advantage (MA) the default option for all enrollees. This is something you essentially called for yourself in 2020 when you outlined a "Medicare Advantage for All" plan. Do you support a policy that would auto-enroll beneficiaries into Medicare Advantage?
    a. Will you oppose the development of Innovation Center models that would auto-enroll beneficiaries into Medicare Advantage?

Response: Seniors deserve to have choices for accessible, high-quality care. If confirmed, I will work to ensure that both traditional Medicare and Medicare Advantage are well administered, effective, and available for eligible beneficiaries.

24. The MA payment system has drawn heightened scrutiny, given research suggesting that payments to plans far exceed spending on comparable beneficiaries who are enrolled in Traditional Medicare. Policy experts have offered several policy changes that could make the MA payment system more competitive and efficient. What is your perspective on this?
    a. How do you think CMS can ensure the most efficient spending of federal dollars to plans, while preserving access and quality of care for enrollees?
25. What will be your approach to addressing prior authorizations and other limits on Medicare enrollees' care in the MA program?
26. MA beneficiaries are filing more appeals for denied services or treatments in recent years. MA enrollees are also more likely than Traditional Medicare enrollees to report delays in care due to required approval. What can CMS do to ensure that beneficiaries are receiving needed care in a timely manner?

Response (24-26): Medicare beneficiaries deserve to have choices in how they receive their Medicare benefit. If confirmed, I will work to improve the Medicare Advantage program, including by looking at ways to address systemic upcoding and the misuse of prior authorization.

27. What steps will you take to make sure that MA plans do not undermine the financial stability of rural hospitals, home health agencies, and other providers?

Response: It is important that rural hospitals remain available to provide care to America's seniors and that they receive timely payments for services provided. If confirmed, I plan to look at all the options to protect and support access to health care, including in rural communities, with the goal of making Americans healthy again.

28. As a physician, how do you think MA Star Ratings are used by patients? Do you believe patients should have access to this information when choosing their Medicare Advantage plan? Do you believe the MA Star Ratings system is indicative of quality?

Response: If confirmed, I look forward to working on ways to make sure that America's seniors are equipped with the information they need to make the best healthcare decisions.

Affordable Care Act

29. For those buying coverage on their own, the enhanced premium tax credits provided in the Inflation Reduction Act have lowered consumers' out-of-pocket costs significantly. Due, in part, to the availability of enhanced premium tax credits, the nation benefited from record enrollment through the ACA marketplaces this year. If these tax credits are not extended, it will drive up health care costs for millions of Americans. This is particularly true in the states where premiums will increase the most – WY, AK, WV – and states where the majority of the funding goes – FL, TX, GA, and NC.
    a. As a physician, do you recommend your patients get health insurance coverage?
    b. During a staff-level, bipartisan briefing with the Committee on Friday, March 7, you expressed support for the extension of the tax credits. Can you affirm your support for keeping enhanced tax credits in place so people can continue to purchase affordable insurance?
30. Over 3 million small business owners and self-employed workers nationwide will face skyrocketing premiums if the enhanced premium tax credits are not extended. These workers do not have the option to receive employer-sponsored coverage. Do you believe the enhanced premium tax credits should remain available for these employers and workers?
31. The expiration of enhanced premium tax credits would lead to an estimated 286,000 job losses nationwide, with nearly half of these job losses occurring in healthcare settings. As CMS Administrator, how would you mitigate these job losses, particularly given the existing shortage of healthcare workers across the country?

Response (29-31): If confirmed I will ensure Americans have access to affordable, high-quality coverage through the programs CMS administers including the ACA Marketplace.

32. Past reporting indicates that you have referred to the Affordable Care Act as "a very brave effort to include more Americans in the healthcare system. The problem with it though is that there was compromise required to get it passed, which limited its ability to address the quality of care and more importantly the cost of care." What policy opportunities do you see to improve and build upon the Affordable Care Act to address the quality and cost of care?

33. The U.S. healthcare system consistently lags behind the health systems of our international peers when it comes to access, outcomes, and efficiency. You have previously spoken positively about the universal health care systems of Germany and Switzerland. What do you like about those countries' systems? What do you think the U.S. could learn and adopt from them?

Response (32-33): If confirmed, I look forward to working with Congress and other agencies across the Administration to understand how we can best ensure high quality care, promote competition, and provide health care at a good price for American patients.

34. What do you believe has been the primary driver of our currently record low rate of uninsured Americans?
35. What do you plan to do at CMS to make sure the downward trend in our nation's uninsured rate continues?
36. Do you support reducing the amount of time that individuals have to shop for insurance during annual open enrollment?
37. Do you support funding for outreach and education efforts to connect low-income people with insurance options, and special enrollment periods to assist them with enrollment in programs they are eligible for?
38. Please describe the importance of zero dollar insurance plans for low-income individuals needing access to affordable health care.
39. Please describe your views as a physician on the relationship between affordable health care and the ability of individuals to remain healthy and productive in the workforce.
40. Do you support administrative requirements for the purchase of insurance that cause eligible individuals to lose their coverage?
41. Do you believe that all low-income taxpayers should have access to affordable health insurance on the ACA Marketplace?

Response (34-41): If confirmed, I will follow the law and work to foster an affordable, accessible, high quality health care system that best meets the needs of individuals and their families.

CMS Innovation Center

42. The Center for Medicare & Medicaid Innovation (Innovation Center) tests and implements new patient-centered, health care delivery models to improve quality while potentially reducing costs in the Medicare and Medicaid program. These models are critical to informing health care delivery. As a physician, are you committed to preserving the Innovation Center and its role in CMS?
43. On March 12, 2025, CMS announced it would modify or discontinue seven models, including several focused on access to primary care, rural communities, and vulnerable populations. Will you commit to the continuation of each of the following models:
    a. GUIDE
    b. AHEAD
    c. ACO REACH
    d. CGT Access

e. Will you commit to early consultation with Finance Committee members and affected stakeholders before CMS alters or withdraws any additional models?

Response (42-43): If confirmed, I plan to work with Secretary Kennedy, Congress, and stakeholders to ensure that the Innovation Center tests appropriate, innovative models that improve the quality of care and reduce costs for Medicare and Medicaid beneficiaries.

44. Please articulate your vision for the Innovation Center as it relates to the Medicare Advantage (MA) program.

Response: CMS should be innovative and explore ideas to improve the Medicare Advantage program to improve the quality of care for patients and reduce costs for Medicare beneficiaries. If confirmed, I will move forward with this agenda consistent with the President's priorities.

45. Will the Innovation Center pursue demonstrations that will auto-enroll participants in MA plans?
46. Will the Innovation Center test prior-authorization within the Traditional Medicare program?

Response: If I am confirmed, I will work with Secretary Kennedy, Congress, and stakeholders to ensure that the Innovation Center tests appropriate, innovative models that improve the quality of care for patients and reduces costs for Medicare beneficiaries.

47. The Making Care Primary model offers support specifically for the small, independent, and oftentimes rural practices that do not have the opportunities nor the means to transition to value based payment. Without this type of non-ACO care model, the Innovation Center leaves only ACO-related primary care models as options. Many rural practices do not have an ACO in their region, so models like Making Care Primary offer the only pathway to alternative payment models and coordinated care. Please describe what entry points rural primary care practices not involved with ACOs have to transition to value-based payment?
48. The Making Care Primary model required participants forgo participation in any other model including the Medicare Shared Savings Program (MSSP). With the sudden termination of MCP, how will the Innovation Center ensure these practices are supported in their transition to other models so they are not forced to return to total fee-for-service payment?
49. The Innovation Center stated in the fact sheet on the model terminations that these actions do not signal a retreat from their commitment to primary care.
    a. How is the Innovation Center going to continue to support primary care when the most prominent primary care models have been terminated?
    b. Winding down participation is time consuming and burdensome for providers. What is the timeline for providing information to practices involved with terminated models?

Response (47-49): If confirmed, I look forward to working with the Innovation Center to provide the best possible care for seniors

Cyber Security and AI

50. Last February, Change Healthcare was hacked by a ransomware group that compromised the health data of more than 100 million Americans.
    a. As CMS Administrator, how will you direct the agency to prepare for and respond to cybersecurity attacks of the health care system?
    b. What actions will you take to ensure the privacy and security of patient health data in the wake of cyber attacks?
51. Are you supportive of additional requirements, not voluntary standards, for hospitals, nursing homes, and other Medicare-certified providers to improve their cybersecurity standards?
    a. Are you supportive of implementing these requirements through the conditions of participation requirements for Medicare providers?
52. For over two decades, the Health Insurance Portability and Accountability Act, or HIPAA, has set federal standards for patient's health information. The existing rules do not require minimum cybersecurity protections of Americans' health data, leaving Americans' sensitive health records vulnerable to hackers. On December 27, 2024, HHS issued a notice of proposed rulemaking to update the HIPAA security rule, proposing to require some basic cybersecurity best practices, such as multi-factor authentication.
    a. Do you agree that the existing HIPAA security regulations are ineffective and are insufficient to protect Americans' health records from hackers?
    b. Do you agree that the December 27, 2024 proposed update to the HIPAA security rule would better protect patient data from hackers?
53. Will you commit to working with other federal agencies to comply with government-wide cybersecurity arrangements or requests for data audits that do not originate in CMS but implicate the agency?

Response (50-53): If confirmed, I look forward to working with partners within HHS and Congress to ensure that American patient data is protected and parties responsible for cybersecurity violations are held accountable.

54. In 2018, a company you co-founded, Sharecare, experienced a data breach that impacted two health care providers and compromised the data of nearly 24,000 patients. According to reports, there was a five month delay between when Sharecare became aware of the breach and when providers were notified. You were a Director at the time.
    a. When were you made aware of the breach?
    b. Why was there a five month delay?
    c. What authority did you have over the decisions made with respect to how the breach was addressed by Sharecare?

Response (a-c): Sharecare was hacked in the Summer of 2018 and hired outside experts to help conduct a forensic review of over a dozen companies which Sharecare owned. Through that process, the company learned that thousands of records were potentially implicated, but no data was compromised. The Sharecare Board was informed along with

the customers in December, 2018 and had no role in addressing hack. The HHS Office of Civil Rights reviewed the Sharecare process and agreed that the company handled the hack correctly.

55. A 2023 investigation found a significant increase in care denials after a Medicare Advantage plan started using an algorithm for prior authorization reviews. In response, CMS issued guidance to improve oversight of AI in these processes.
    a. As CMS administrator, how would you leverage AI to make our health system more efficient without compromising patient care?
    b. Do you support stronger safeguards for AI in claims approvals and eligibility determinations?

Response: If confirmed, I will look for ways to better optimizing automation, including potentially using artificial intelligence.

Health Equity

56. The White House released an Executive Order directing the CMS Health Equity Advisory Committee to be shut down. As a physician, what are your views on this directive?
57. As a physician**,** do you believe that systemic racism leads to systemic health inequities?
58. As a physician**,** do you believe that healthcare is a right?
59. As a physician, what have you observed to be the impacts of the following health-related social needs on patient health?
    a. Housing insecurity
    b. Food insecurity
    c. Lack of transportation

Response (56-59): If confirmed, I will ensure Americans have access to affordable, high-quality coverage through the programs CMS administers.

60. On March 4, 2025, CMS rescinded two documents that allow states to apply for funding to cover one-time rent payments and home-delivered meals. Do you believe these services are important for patients?
    a. Will you commit to restoring these opportunities for patients on Medicaid?

Response: If confirmed, I will work to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

Conflicts of Interest

61. In 2014, during a hearing in front of the Senate subcommittee on consumer protection, you stated that your claims on the Dr. Oz TV show often "don't have the scientific muster to present as fact." As CMS Administrator, will you choose to prioritize treatments and methods that do have the "scientific muster" to help patients?

Response: If confirmed I will prioritize gold standard science and radical transparency into CMS decision making, in alignment with Secretary Kennedy and President Trump's agenda.

62. The *New York Times* recently reported that you were a licensed broker for TZ Insurance, the subsidiary of a large Medicare Advantage marketing organization, in nearly every state in the country. Is this license currently active? If so, in what states?

Response: I obtained an insurance brokerage license in order to explore potential business opportunities that I ultimately decided not to pursue. While my registrations may still be active in some states, I am not currently engaged as a broker of insurance products in any jurisdiction.

63. In your Insurance Producer license with the State of Tennessee the Business address, Business primary phone, and Business email were all associated with TZ Insurance.
    a. Why was your license associated with TZ Insurance?
    b. Did you approach TZ Insurance for the purpose of being licensed? Did they engage you?
    c. What was your relationship with TZ Insurance with respect to being licensed?

Response: As part of the diligence process to explore a potential business opportunity with TZ Insurance, I obtained applicable insurance licenses. Because I did not ultimately pursue this opportunity, I have never acted as an insurance broker even though I was licensed to do so.

64. If confirmed, do you commit to not selling, promoting, or working for Medicare Advantage (MA) plans following your tenure as CMS Administrator?

Response: I take seriously the obligations of CMS Administrator and, if confirmed, I will uphold the oath to faithfully discharge my duties. In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential conflicts of interest. As part of that process, I have consented to an ethics agreement, resigned from positions, and divested nearly 100 financial holdings in order to comply with the applicable ethics laws and regulations. As a result, the Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest.

65. You committed in your Ethics Agreement to divest your financial interests in companies like iHerb LLC, EKO Health Inc., and Housey Pharma. Can you commit to not placing these, and other health care related interests, in a Trust or in any way transferring these interests, for the benefit of anyone in your family?

Response: In connection with the nomination process, I consulted with the Office of Government Ethics and the HHS Designated Agency Ethics Official to identify potential

conflicts of interest and have entered into an ethics agreement to avoid any actual or apparent conflict of interest. I am committed to upholding the commitments that I have made in the agreement. During that process, I also obtained guidance from the ethics officials to ensure that any required divestitures are accomplished in full compliance with the law and governing regulations. The Office of Government Ethics and the HHS Designated Agency Ethics Official have certified that I am in compliance with the applicable laws and regulations governing conflicts of interest.

Improper payments

One of the targets of the Trump Administration's alleged attempt to reduce waste, fraud, and abuse is the rate of improper payments in Medicare and Medicaid. These improper payments can result from insufficient documentation as well as lack of verified eligibility. However, a CMS report from 2024 shows that improper payments amount to less than 10% of total payments in all CMS programs.

66. What proportion of improper payments in Medicare are attributable to insufficient documentation? And what proportion of improper payments can be attributed to fraud using the Govt. Accountability Office (GAO) definition of fraud?
    i. For reference, the GAO defines fraud as: The act of obtaining something of value through willful misrepresentation, which is determined through a court or other adjudicative system.
67. In light of Trump Administration concerns about improper payments, what steps will you take to enhance transparency and accountability in the measurement and reporting of improper payments?
68. Under the GAO definition of fraud, for the most recent fiscal year for which information is available, what is the total dollar amount of fraud committed against the Medicaid program?
    a. What is the federal share of this total dollar amount?
    b. How much of this total dollar amount is attributable to fraud committed by health care providers?
69. GAO distinguishes improper payments from fraud as follows: "Improper payments are any payments that should not have been made or that were made in an incorrect amount, which can stem from various causes, including fraud. Fraud involves obtaining a thing of value through willful misrepresentation. Willful misrepresentation can be characterized by making material false statements of fact based on actual knowledge, deliberate ignorance, or reckless disregard of falsity." The Medicaid improper payment rate in 2024 (covering reporting years 2022, 2023, and 2024) is estimated to be 5.09%. That translates into $31.1 billion in federal Medicaid improper payments in 2024.
    a. Using the GAO definitions, how much of that $31.1 billion in improper payments is attributable to fraud against the Medicaid program?
    b. Of the amount of improper payments attributable to fraud, how much is attributable to fraud committed by health care providers?
    c. As a physician, did you ever receive an improper payment? If so, did your improper payment constitute fraud under the GAO definition?

Response (66-69): I am committed to making sure that CMS is safeguarding taxpayer dollars to ensure the sustainability of critical programs. If confirmed, I will ensure that

CMS uses every available tool to address improper payments and insufficient documentation while working closely with law enforcement to root out potential fraud.

Long-Term Care/Hospice

70. Last year, the Biden-Harris Administration finalized minimum staffing standards for Medicare- and Medicaid-certified nursing homes.
    a. Will you oppose efforts to roll back the final nursing home staffing rule?
    b. Will you commit to implementing the final nursing home staffing rule?
    c. Will you commit to implement the final rule's requirement for nursing homes to provide a minimum total nurse staffing standard of 3.48 hours per resident day?
    d. Will you commit to implement the final rule's requirement for nursing homes to provide a minimum of 0.55 registered nurse (RN) hours per resident day?
    e. Will you commit to implement the final rule's requirement for nursing homes to provide a minimum of 2.45 nurse aide (NA) hours per resident day?
    f. Will you commit to implement the final rule's requirement for nursing homes to have an RN on site 24 hours a day, 7 days a week?
    g. Will you commit to implement the final rule's hardship exemptions for facilities located in areas with disproportionate shortages of long-term care workers?
    h. Will you commit to implement the final rule's staggered implementation timeline, that provides rural nursing homes 5 years to comply with all requirements and non-rural nursing homes 3 years to comply?
    i. Will you commit to implement the final rule's additional reporting requirements for states to report the percentage of Medicaid payments for services in nursing homes and other facilities that are spent on compensation for direct care workers and support staff?
    j. Will you commit to implement the final rule's requirement for nursing homes to assess and document staffing needs based on resident acuity levels, a requirement that is already in effect?
    k. If not, do you intend to roll back the final nursing home staffing rule if you are confirmed as CMS Administrator?

Response: If confirmed, I will work within CMS to ensure nursing home residents receive safe, high-quality care.

71. What specific steps will you take to ensure that CMS has the personnel and other resources it needs to oversee the quality of care provided in America's nursing homes?
72. Do you support the survey and certification program that oversees the quality of care in nursing homes?
    a. Does this program address waste, fraud, and abuse in America's nursing homes?
    b. Do you believe this program is adequately funded?
    c. Do you believe this program is adequately staffed?

Response (71-72): The quality of care in nursing homes is a top priority, and ensuring proper oversight in this area is important. If confirmed, I look forward to exploring ways to reinforce and strengthen CMS's efforts to oversee and survey these facilities.

73. Medicaid is the primary payer for long-term care in the United States, particularly for older adults and people with disabilities. Do you believe cutting the program by billions of dollars will impact those receiving long-term care through Medicaid?
74. Since 2013, home and community-based services (HCBS) accounted for a majority of Medicaid long-term services and supports (LTSS) spending, making it possible for 4.5 million older adults and people with disabilities to remain at home.
    a. Do you oppose cuts to Medicaid that would limit states' ability to offer home- and community-based services?

Response: If confirmed, I will work to ensure that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens.

75. Do you believe direct service providers of long-term care should be paid a living wage?

Response: If confirmed, I will ensure long-term care services continue to play an important role in making sure America's seniors can access the care they need.

76. An increasing number of nursing homes are being purchased by large private equity firms. Data shows that nursing home quality is significantly reduced when nursing homes are purchased by private equity despite the same or higher costs.
    a. Will you continue CMS' efforts to increase transparency and accountability for large private equity owned nursing homes to ensure Medicaid and Medicare funds are properly utilized towards residents' care?

Response: If confirmed, I will work to provide seniors and caregivers with information to make informed decisions when it comes to their health care decisions.

77. The hospice special focus program (SFP) identifies poor performing hospices based on quality metrics. Earlier this year, CMS paused implementation of the hospice SFP. Do you intend to restart the hospice SFP program?
        i. Do you agree that the hospice SFP program identifies fraud and abuse of the Medicare hospice benefit?
        ii. What specific steps will you take to protect Medicare beneficiaries from fraudulent actors taking advantage of the Medicare hospice benefit and abusing seniors?

Response: I share your interest in ensuring that Medicare beneficiaries have access to high-quality hospice care. If confirmed, I will further review the details of the Hospice Special Focus Program and work with the CMS team and Congress to make sure that the program identifies the poorest performing hospices and takes appropriate enforcement actions.

Medicaid

78. As a physician, will you commit to opposing Medicaid cuts that could deprive tens of millions of Americans of health care coverage?

Response: If confirmed, I would work to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

79. In states like Arkansas and Georgia, Medicaid work reporting has caused thousands of eligible people to lose coverage or has prevented eligible people from signing up, even if they are working. As a physician, do you believe remaining healthy is an important prerequisite to working?

a. Do you think losing one's health insurance puts one's health at-risk?
b. Does losing health insurance impact one's ability to participate in the workforce?

Response: Community engagement empowers individuals and fosters a sense of purpose and dignity. I look forward to empowering states with the flexibility to tailor their Medicaid program in ways that best serve their populations while efficiently using taxpayer dollars and promoting personal responsibility.

80. States have flexibility to tailor their Medicaid programs through the 1115 waiver pathway–and Secretary Kennedy and the Trump Administration have purported to value state flexibility. The National Governors Association (NGA) continues to press on a bipartisan basis for states to have broad flexibility to use 1115 Medicaid waivers for innovation. However, CMS' first Medicaid policy directive was to rescind 1115 waiver guidance related to health-related social needs, for which 25 states have received federal approval.

a. What will your approach be to state demonstrations through 1115 waivers?
b. Can states rely on you to maintain and extend their existing 1115 waivers?

Response (a-b): If confirmed, I will work with states to help identify strategies to support innovation and improvement in Medicaid and CHIP. I will consider states' Section 1115 waivers on a case-by-case basis to ensure they are consistent with Medicaid program requirements and objectives.

81. Most states rely on managed care organizations (MCOs)—or private insurers contracted by the state—to cover and deliver services to Medicaid beneficiaries. As enrollment and spending on MCOs have grown, so too has policymakers' scrutiny of how these contracts are secured and managed. How will you promote greater oversight, accountability and transparency in Medicaid MCO contracting and procurement?

a. Will you commit to fully implementing and enforcing the Managed Care Rule finalized in May 2024?

Response: If confirmed, I would work to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

82. Over 40 states have expanded Medicaid under the Affordable Care Act, significantly reducing uninsured rates among low-income individuals. Do you believe all states should expand Medicaid, and if not, how would you address the coverage gap for low-income adults who are unable to enroll in other sources of coverage in non-expansion states?

Response: If confirmed, I would work to partner with states to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fits the needs of their citizens, ensure quality, and improve health outcomes.

83. Today, 24 million women are enrolled in Medicaid, 56 percent of whom are in their reproductive years and over half of whom are women of color. As the nation's largest payer for maternal health, covering 41 percent of births nationwide, Medicaid is essential to improving outcomes for mothers and infants nationwide.
a. Do you support terminating pregnant women's health care during our country's ongoing maternity care crisis?
b. What is your plan for improving maternal health through Medicaid as head of our nation's largest maternity care payer?

Response: If confirmed, I will work to promote a health care system that will provide access to quality care while ensuring patients are able to make decisions that work best for them. I will also work with states to help them achieve their goals with as much flexibility as possible, consistent with Medicaid program requirements and objectives.

84. Analysis of data from the CDC showed that the number of children below age three who had received all doses of seven recommended childhood vaccines in 2023 has fallen in many states from five years prior. Vaccination rates have also declined among kids enrolled in Medicaid and CHIP for all vaccines except influenza, compared to years prior. These trends have serious public health implications.
a. If confirmed as CMS Administrator, how will you address declining vaccination rates among communities and states, particularly among those enrolled in Medicaid and CHIP?

Response: If confirmed, I will follow the law and work with states to ensure that recommended vaccines are covered.

85. Medicaid unwinding brought to light long-standing issues with Medicaid enrollment and eligibility processes–with nearly 70% of those who lost their Medicaid coverage losing it due to procedural reasons. Will you commit to fully implementing and enforcing the Medicaid Eligibility and Enrollment Rule finalized in September 2023 and April 2024?

Response: It is important that Medicaid resources and participating providers are available to provide care for those who are eligible for the program. If confirmed, I look forward to reviewing how states can improve the enrollment process.

86. Do you believe children eligible for CHIP should be allowed to be subjected to a waiting period in order to enroll in CHIP?
87. Do you believe children eligible for CHIP should be subjected to annual or lifetime dollar limits for services such as dental care?
88. Do you believe that children eligible for CHIP should be locked out of their coverage for non-payment of premiums?

Response (86-88): Each state has different needs, and I believe CMS needs to work with states to ensure that, consistent with those needs, state CHIP programs provide the best possible coverage to their residents.

89. Many children with rare pediatric diseases have severe functional limitations and qualify for Medicaid on the basis of disability. Additionally, many parents of rare disease patients are unable to work because of their caregiving responsibilities or/and rely on Medicaid to pay for in-home or institutional care for their children. How will you ensure that these children and families maintain their Medicaid coverage and access to medically necessary healthcare and life supports?

Response: If confirmed, I will seek to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

90. Firearm violence leads to an average of 50,000 emergency room visits and 30,000 in-patient stays as well as an estimated $1 billion in direct medical costs each year. As you noted in a 2019 op-ed you co-authored, Medicaid covers a significant percent of these medical costs. What role do you believe Medicaid should play in addressing firearm violence?
91. Do you believe firearm violence is a public health issue?
92. Do you support hospital-based violence intervention programs to prevent and address firearm violence?

Response 90-92: Firearm violence is wrong and tragic. During my surgical training in Spanish Harlem, I opened the chests of gunshot victims to provide critical care frequently. The factors that lead to these tragedies are multi-faceted and we should all be working toward their reduction.

93. Senator Tillis noted during your confirmation hearing that Medicaid expansion is "working pretty well" in North Carolina–with nearly 650,000 people currently enrolled. However, North Carolina is one of nine states with a "trigger law" that will automatically terminate expansion coverage if the federal medical assistance percentage (FMAP) drops below 90%. Other states would likely terminate Medicaid expansion coverage as well, given the significant cost-shift to states.
    a. Do you oppose proposals terminating enhanced federal funding for the more than 20 million people with Medicaid expansion coverage?

b. How would you respond to millions of people losing their Medicaid coverage and being unable to access other coverage sources?

Response: Medicaid expansion is a state decision under the law. If confirmed, I would work to partner with states to ensure that the Medicaid program is well administered, effective, and available for the most vulnerable beneficiaries and that the states are given the flexibility to pursue innovative approaches that fit the needs of their citizens, ensure quality, and improve health outcomes.

No Surprises Act

94. The No Surprises Act (NSA) mandates that commercial insurers and providers use an independent dispute resolution (IDR) process when a billing reimbursement is denied, with CMS responsible for enforcing timely decisions and payments. However, disputes are now dragging on for over a year, leaving many nonprofit emergency transport services underfunded and at financial risk. As a champion in fighting waste, fraud, and abuse, will you utilize the enforcement mechanisms within the NSA to hold commercial insurers accountable?

95. How does CMS plan to ensure compliance with the law—protecting patients from denied claims and ensuring timely provider payments—given that recent staff reductions have weakened the very branches responsible for enforcing these protections?

Response (94-95): If confirmed, I will follow the law and work to ensure that patients are protected and have the price information they need to make informed decisions about their care.

Organ Transplantation

96. The Senate Finance Committee has been conducting an almost five-year bipartisan investigation into the failings of monopoly organ contractors, including both organ procurement organizations (OPOs) and the national organ procurement and transplantation network (OPTN). Despite clear findings of deadly patient safety lapses and lacking oversight, serious concerns persist about the adequacy of the U.S. Department of Health and Human Services' oversight of this critical area of health care. What steps would you take to address this challenge?
97. OPOs have historically had their performance measured through uneven and incomprehensive metrics. Notably, the *New York Times* recently investigated how increased out-of-sequence organ allocation leads to the sickest patients at the top of the waitlist being skipped and denied offers for organs that could save their lives. What are your views on oversight of OPOs and on needed reforms to the organ transplant system?
    a. If confirmed, will you enforce the OPO performance metrics finalized in 2020 and carry out decertification of under-performing OPOs?

Response (96-97): If confirmed, I look forward to working closely with Congress on accomplishing this goal, including holding OPOs accountable for their performance and

building on the progress made to date pursuant to President Trump's Executive Order Advancing American Kidney Health.

98. Previously, you have suggested that a potential solution for donor organ shortages is to pay impoverished people in countries like India $20,000 to donate partial livers, lungs, and kidneys. Do you believe harvesting organs from residents of impoverished nations is an ethical solution to the deficit of transplantable organs in the United States?

Response: I do not recall suggesting this approach. Organs should not be sold. Each country should consider its own approach to improving organ donation.

Prescription Drugs

99. As CMS Administrator, what steps will you take to lower the price of prescription drugs for Americans? Please be specific.
100. Do you think President Trump will succeed at negotiating lower drug prices for seniors and people with disabilities through Medicare drug price negotiation?
101. Secretary Kennedy refused to commit in writing to using Medicare drug price negotiation to get the best deal possible for seniors and people with disabilities on prescription drug prices. In your confirmation hearing on March 14, when pressed about the Medicare drug price negotiation program, you stated, "It's the law. I am going to defend it and use it." Please affirm this commitment in writing.
102. Big Pharma's request to "pause" negotiation is clearly unlawful, especially given the specific duties and timelines for the Secretary under the Inflation Reduction Act's negotiation provisions. Secretary Kennedy committed to "follow the law in implementing CMS programs." Please confirm in writing that you will follow the law and reject Big Pharma's request to pause Medicare drug price negotiation.
103. Will you commit to rejecting use of demonstration authorities, such as those under Section 402 and Section 1115A, to change Medicare drug price negotiation in a manner that would increase drug costs for seniors and people with disabilities, reduce the number of drugs eligible for negotiation, or delay negotiations on certain drugs?
104. Will you commit to rejecting changes to the Medicare drug negotiation guidance that would increase drug costs for seniors and people with disabilities, reduce the number of drugs eligible for negotiation, or delay negotiations on certain drugs?
105. In your role as CMS Administrator, you would advise President Trump on major health policy issues before Congress. Would you recommend that President Trump oppose legislative changes to Medicare drug price negotiation that would increase drug costs for seniors and people with disabilities, reduce the number of drugs eligible for negotiation, or delay negotiations on certain drugs?
106. Under the law's Medicare drug price negotiation provisions, Medicare can negotiate lower prices on small molecule drugs seven years after those drugs have been approved by FDA—with lower negotiated prices taking effect in Medicare after nine years. One of the items on Big Pharma's policy wish list is to delay seniors' and other beneficiaries' access to lower prices on small molecule drugs until such drugs have been on the market for 13 years. This policy change would delay Medicare beneficiaries' access to lower Medicare-negotiated prices on small molecule drugs for years. Do you think it's fair to ask seniors to wait another four years to get lower prices on these medicines?

107. Another item on Big Pharma's policy wish list is to reduce the number of drugs eligible for negotiation by changing the definition of "qualified single source drug." Would you oppose changes to or reinterpretations of this definition that would reduce beneficiaries' access to lower negotiated prices?
108. Earlier this year, House Republicans circulated a survey of policy options for their reconciliation package. The survey asked for member feedback on adding up to $20 billion to our deficit to "Reform IRA's Drug Policies." Republicans appear to be considering providing a massive multi-billion handout to Big Pharma on the backs of taxpayers, seniors, and people with disabilities. Would you encourage President Trump to oppose including Big Pharma IRA handouts in the Republican reconciliation package?
109. Will you ensure that maximum fair prices negotiated by the Biden-Harris Administration for the first 10 selected drugs go into effect on January 1, 2026?
110. What would you do differently in negotiating the second round of drugs compared to the first?
111. In your role as CMS Administrator, you would oversee the implementation of the first round of negotiated prices. What will you do if pharmacies are not promptly given access to these prices by manufacturers?

Response (99-111): The issue of drug pricing is one of great concern to Americans. President Trump has made it clear that he wants to reduce drug prices both in terms of what the government pays and what Americans pay. I plan to follow the laws, including all the recent changes to the Part D drug benefit, and work with the President and Congress to identify other levers to lower prescription drug prices for all Americans.

112. Do you think the prices charged by pharmaceutical companies in the United States are fair?
113. Do you believe patients in the United States are paying too much for prescription drugs relative to European countries?
114. Why do you believe the United States pays more for prescription drugs than European countries?
115. Do you support the Most Favored Nation/International Pricing Index policy Trump advanced during his first administration?
116. Have Trump, Musk, Secretary Kennedy or any other White House, DOGE, or HHS officials suggested to you that they are considering reviving his International Pricing Index/Most Favored Nation model?
117. On July 25, 2019, Republican Finance Committee members including Senators Crapo, Cornyn, Cassidy, Thune, Scott, Lankford, Daines, and Young voted in favor of an amendment during a Committee markup that would have prohibited the Trump Administration from implementing his International Pricing Index/Most Favored Nation model with respect to most Medicare Part B drugs. Do you agree that most Part B drugs should be exempt from Trump Administration policies intending to bring prescription drug prices in the United States more in line with European prices?

Response (112-117): Lowering the cost of prescription drugs for Americans is a top priority of President Trump and his Administration. If confirmed, I plan to follow the law.

Reproductive Health Care

118. You are on the record as saying you wanted "local political leaders" involved with women and doctors when making decisions about reproductive health care. Medicaid covers over 40% of births in the U.S. and you would be responsible for overseeing that program. As a physician, how do you plan to involve local political leaders in medical decisions that should be made between a patient and their doctor?

Response: Patients and doctors should be free to make health care decisions, within the bounds of the law. Regarding abortion, I believe every abortion is a tragedy, and I support President Trump's position that States should control their own laws on abortion.

119. As CMS Administrator, you will supervise the enforcement of the Emergency Medical Treatment and Labor Act (EMTALA), federal law that requires hospital emergency departments to provide "stabilizing treatment," such as emergency abortion care, when a patient presents with an emergency medical condition.
    a. As a physician, will you commit to ensuring that patients at hospital emergency departments have access to emergency life and health-saving care when they need it, including emergency reproductive health care?
    b. Will you preserve federal guidance that clarifies that hospital emergency departments must provide emergency abortion care under EMTALA's requirements?
    c. Will you commit to make sure that CMS has the resources and personnel it needs to investigate complaints of EMTALA violations?

Response: If confirmed, I will follow the law.

Traditional Medicare

120. Do you support the Traditional Medicare program?
121. Do you believe beneficiaries should always be able to choose Traditional Medicare?

Response (120-121): The President has been very clear about his support for Medicare. If confirmed, I would work as CMS Administrator to ensure that Medicare is well administered, effective, and available for eligible beneficiaries.

122. Do you believe a high-performing Accountable Care Organization (ACO) can meet beneficiary needs and coordinate care?

Response: Health care expenditures are growing two to three percent faster than our economy, which is not sustainable. We need to look to value-based solutions to help control costs while ensuring that beneficiaries have access to high quality care that is coordinated between their providers. If confirmed, I look forward to examining more ways to promote high quality care that drives better outcomes.

123. A variety of stakeholders have argued that we need to overhaul how Medicare pays physicians. What is your opinion on the role the RUC plays in advising physician fee schedules?

a. How, if at all, would you support reforming the RUC or the way in which CMS reviews the recommendations from the RUC?
b. How will you ensure appropriate access to primary care through the Physician Fee Schedule Updates?
c. What will you do to ensure that the Medicare Physician Fee Schedule supports sustainable reimbursement for home-based primary care, so that our system is adequately prepared to meet the health care needs of the aging population?

Response (a-c): Physicians play an important role in supporting healthy lifestyles for patients and making sure America's seniors can access the care they need. If confirmed, I commit to working with Congress on making the coding and physician payment rate setting processes more transparent and in alignment with the important role that primary care physicians play.

124. The Biden Administration finalized Conditions of Participation (CoPs) requirements for hospitals that participate in the Medicare program that focused on improved access to maternal health care. Do you intend to roll back these CoPs?

Response: If confirmed, I will examine maternal healthcare policies and programs within CMS and work to improve maternal and infant health outcomes.

125. As a physician, do you think patients should have access to physician performance ratings in the MIPS program? What types of reforms would you consider in order to maximize the value of these data for patients?

Response: If confirmed, I will work to ensure that seniors and their families have the information they need to choose quality care.

Vaccines

126. As a physician, do you believe it is important for all children and adults on Medicaid and Medicare to have access to lifesaving vaccines?
127. The Inflation Reduction Act provided a mechanism to protect Medicare beneficiaries from vaccine-preventable diseases by requiring Medicare drug plans to make vaccines recommended by the Advisory Committee on Immunization Practices free for enrollees. The IRA requirement guarantees nearly 54 million Medicare Part D beneficiaries access to free vaccines.
    a. Do you support this benefit?
    b. Will you preserve it?

Response (126-127): Both Medicaid and Medicare Part D plans generally cover recommended vaccines with no cost sharing. If confirmed, I will follow the law.

128. Do you think Secretary Kennedy's response to the measles outbreak in the Southwest has been appropriate?
129. Secretary Kennedy said during a Fox News interview that the MMR vaccine "causes deaths every year" and "causes all the illnesses measles itself causes."

a. Do you think these comments fairly characterize the risks associated with the MMR vaccine?
b. Were these helpful comments for Secretary Kennedy to make during a measles outbreak that has put children's lives on the line?

Response (128-129(a-b)): Earlier this month, Secretary Kennedy stated, "Vaccines not only protect individual children from measles, but also contribute to community immunity, protecting those who are unable to be vaccinated due to medical reasons." I agree with this statement.

130. Do you believe the measles vaccine is safe?

Response: Yes

131. Two doses of the MMR vaccine have been shown to be 97 percent effective at preventing measles. Do you agree the measles vaccine is effective?

Response: Yes

132. Do you believe the current measles outbreak in the Southwest is being driven at least in part by lack of vaccination?

Response: I am unfamiliar with the epidemiological details of the measles outbreak in the Southwest. I support children receiving the measles vaccine.

133. As a physician, which do you believe is safer for patients: (1) vaccination against measles; or (2) lack of vaccination against measles followed by treatment with vitamin A and/or cod liver oil?

Response: As Secretary Kennedy has stated, "Vaccines not only protect individual children from measles, but also contribute to community immunity, protecting those who are unable to be vaccinated due to medical reasons." I agree with this statement.

134. During Secretary Kennedy's confirmation hearing, he refused to state that vaccines do not cause autism, despite decades of evidence demonstrating the safety of vaccines. As a physician, can you unequivocally state that vaccines do not cause autism?

Response: I do not believe a single vaccine dose causes autism.

Other Topics

135. Do you believe that research conducted at academic and non-profit institutions is important for public health? Will you commit to ensuring that CMS data continues to be available and affordable to academic and non-profit researchers?

Response: As a physician who has published hundreds of peer-reviewed academic articles in some of our top journals, I understand the value of research and data. If confirmed, I will work to ensure transparency with CMS data consistent with the law. By empowering Americans with transparency, CMS can help drive innovation and support people in better navigating their health.

136. The Congress and the Administration are considering a variety of health policy initiatives where there is either conflicting evidence or an absence of systematic evidence. How will CMS use the analytic capacity contained in the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) to advise on the detailed policy options required to make sound choices?
    a. Under your leadership, would CMS continue to partner with ASPE to analyze data, conduct research, and carry out evaluations on CMS programs?

Response: As a physician who has published hundreds of peer-reviewed academic articles in some of our top journals, I understand the value of research and data. If confirmed, I will work to ensure that CMS programs rely on high quality data.

137. Quality Improvement Organizations (QIO) comprise a vital network of experts, clinicians, and consumers working to improve the quality of care Medicare beneficiaries receive. QIOs address beneficiary complaints, improve care processes, ensure payment accuracy, and analyze data to enhance care quality, among other essential activities. It is rumored that CMS leadership – under the direction of the DOGE – is entertaining an up to 50% cut in QIO funding. Will you commit to sustaining QIO funding at levels approved in the most recent statement of work?
    a. What is the rationale for considering such cuts, and what specific cuts proposed by CMS leadership would you deem acceptable?
    b. If you determine that any DOGE-recommended cuts will harm beneficiary care and quality, will you reject these recommendations and prevent cuts?

Response: I have not been involved in decision-making about these topics, and if confirmed, improving quality through CMS programs will be a top priority.

Connections to the Turkish Government and Its Interests

138. In 2019, in light of overwhelming historical evidence, all 100 members of the US Senate voted to condemn the Ottoman Empire's mass targeted violence campaign that killed over 1.5 million Armenians during and after World War I as a genocide. Indeed, according to Raphael Lemkin, the creator of the term 'genocide,' this violence was what inspired him to begin the work that resulted in his coining the term. You, however, have repeatedly refused to discuss or condemn the Armenian genocide, stating only (through a spokesperson) that the "evils of World War I should be commemorated" and that you "oppose[] genocide."[27] Moral courage and a willingness to acknowledge facts are

[27] Alex Seitz-Wald, "Trump is backing Oz's Pa. Senate bid. Armenian Americans are skeptical," NBC News, April 19, 2022, https://www.nbcnews.com/politics/politics-news/armenian-americans-rally-opposition-ozs-pennsylvania-senate-bid-rcna24084

essential characteristics for nominees for high-ranking Administration positions, including CMS Administrator.

a. Yes or no, do you believe that the Armenian genocide occurred? Please do not merely state that you oppose violence or that Armenian communities suffered during World War I and instead answer whether you personally believe there was a genocide against Armenians.

Response: Genocide in all its forms is a tragedy. If confirmed I look forward to addressing critical issues at CMS and improving access to care for all Americans.

139. Your significant connections to the Turkish government, some of which may have violated US law, raise concerns about your fitness to prioritize the interests of the United States over those of foreign governments as CMS Administrator. You have repeatedly appeared in advertising campaigns for Turkish Airlines (which is 49.12% owned by the Turkish government), without registering as a foreign agent, potentially in violation of the Foreign Agents Registration Act.[28] You also lease one of your properties for free to the Turkish government and were elected in 2011 to the High Advisory Council of the World Turkish Business Council— part of the Foreign Economic Relations Board, which is controlled by the Turkish government and which, in its own words, is Turkey's "window to the world," "act[ing] to improve Türkiye's trade and investment relations in a strategic manner…conducting the foreign economic relations…under the coordination of the Ministry of Trade."[29] Additionally, in 2019, you were photographed arm in arm with Abdulhamit Gül, Turkey's former Minister of Justice, who, just months prior to your meeting, was sanctioned by the Trump Administration Treasury Department for "serious human rights abuses," including the unjust detention of an American pastor.[30]

a. What affiliation do you currently have with the World Turkish Business Council or the Foreign Economic Relations Board?

Response: None.

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[28] Ovunc Kutlu, "Turkish Airlines cements global brand power with Dr. Oz," Anadolu Agency, 9/2/2018, https://www.aa.com.tr/en/americas/turkish-airlines-cements-global-brand-power-with-dr-oz/1058431

[29] United States Senate Financial Disclosures, Candidate Report of Mehmet Oz, https://static.politico.com/37/49/989ab9d74460ac214c3610072fc1/efd-annual-report-for-2022-oz-mehmet-c.pdf Anadolu Agency, "Famous names in management of diaspora," November 20, 2011. https://www.aa.com.tr/en/archive/famous-names-in-management-of-diaspora/392856 DEİK, "About Us," https://www.deik.org.tr/deik-about-us

[30] Anadolu Agency, "Dr. Oz hails Turkish heritage in parade," June 10, 2019, https://www.hurriyetdailynews.com/dr-oz-hails-turkish-heritage-in-parade-144069 (including photo). US Department of Treasury, "Treasury Sanctions Turkish Officials with Leading Roles in Unjust Detention of U.S. Pastor Andrew Brunson," August 1, 2018, https://home.treasury.gov/news/press-releases/sm453

b. Yes or no: if confirmed, will you commit to severing all ties to the Turkish government, including your affiliations with the World Turkish Business Council and Turkish Airlines? Please do not merely state that you will comply with all relevant laws and regulations, but rather answer whether you will continue these affiliations.

c. Why should the American people trust that a senior Administration nominee with such tight connections to a foreign government will not be improperly influenced by that government and its interests?

Response (b-c): I do not have any current affiliations with the World Turkish Business Council, Turkish Airlines, or the Turkish government. If confirmed I will follow the guidance of the Office of Government Ethics and agency counsel.

d. You previously stated that you would renounce your Turkish citizenship if elected to the Senate, but have not made such a commitment about taking this step if confirmed as CMS Administrator. Why has your position changed?

Response: I have chosen to retain my dual citizenship to better facilitate care for my aging mother, who, like millions of Americans, suffers from Alzheimer's. If confirmed I will follow all legal and ethical guidance related to this issue.

e. Were you aware that Abdulhamit Gül was sanctioned by the Administration you are now seeking to serve when you met with him in 2019?

Response: No.