

**PRESIDENT'S FISCAL YEAR 2013
HEALTH CARE PROPOSALS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TWELFTH CONGRESS
SECOND SESSION

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FEBRUARY 15, 2012
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Printed for the use of the Committee on Finance

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U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 2012

78-384—PDF

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PRESIDENT'S FISCAL YEAR 2013 HEALTH CARE PROPOSALS

WEDNESDAY, FEBRUARY 15, 2012

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

The hearing was convened, pursuant to notice, at 10:40 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Wyden, Menendez, Carper, Cardin, Hatch, Grassley, Snowe, Crapo, Roberts, Enzi, Cornyn, Coburn, and Thune.

Also present: Democratic Staff: David Schwartz, Chief Health Counsel; Matt Kazan, Professional Staff; Tony Clapsis, Professional Staff; Callan Smith, Research Assistant; and David Sklar, Health Fellow. Republican Staff: Brendan Dunn, Special Counsel; and Stephanie Carlton, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

President Dwight Eisenhower once said, "Unless we progress, we regress." Since passing the Affordable Care Act, we have made tremendous progress on the health care front. Health reform is saving millions of Americans money, giving them more choices and better access to their doctors. Prescription drugs are cheaper for seniors. In fact, 3.6 million Medicare beneficiaries saved more than \$2 billion last year, and that is because health care reform closes the prescription drug donut hole.

To date, 2.5 million young adults, many facing a difficult job market, have been able to stay on their parents' coverage. Forty thousand Americans who were denied insurance due to a pre-existing health condition have been able to obtain coverage through State-based high-risk pools.

Vera Uzelac from Billings, MT can tell you just how health care reform has helped her. Like most seniors, Vera lives on a fixed income and has to be conscious of every penny she spends to get by. Before health reform, Vera was forced to pay as much as \$85 a month for one prescription, but now Vera is saving at least \$20 every month on medications she needs, which frees up money for groceries and other necessities.

Or take Sheila Lopach from Helena, MT, whose 24-year-old daughter is in school and had no health coverage. Thanks to health reform, young adults across the country like Sheila's daughter can

stay on their parents' insurance coverage, and parents like Sheila can worry a little bit less.

Just as health reform reduced costs for individuals and businesses, the law reduced government costs, most notably through Medicare. The health reform law also provided the biggest deficit reduction in more than a decade. According to our nonpartisan scorekeeper, the Congressional Budget Office, the law will reduce deficits by \$143 billion in its first 10 years and by more than \$1 trillion in the decade that follows. We need to continue this progress. I look forward to hearing from Health and Human Services Secretary Kathleen Sebelius today about how the President's budget will do that.

Today nearly 48 million Americans are enrolled in Medicare. As the Baby Boom generation retires, the number of seniors eligible for Medicare will increase rapidly. Over the next decade, 18 million additional Americans will enroll in Medicare. We need to ensure that these beneficiaries and future generations receive the benefits that Medicare guarantees.

To strengthen Medicare, we need to continue lowering costs. We need to spend our precious health care dollars more wisely and efficiently. If we do, we will lower premiums for seniors enrolled in Medicare today and keep the program strong for generations to come.

This is the path health care reform took, and we are already seeing results. Two weeks ago, CBO released a report showing that over the next 10 years the cost-per-beneficiary will average just 1 percent a year more than the rate of inflation.

This is significantly better than the last 20 years. From 1985 to 2007, these costs grew 5 percent faster than inflation—not 1 percent, 5 percent. This is major progress, but of course we can do more. If per capita health care costs were to slow by 1 percentage point over 10 years, the Federal Government would save \$800 billion.

Secretary Sebelius, we provided you with the tools in the Affordable Care Act to continue to lower costs and bend the cost curve. When doctors and hospitals do not talk to each other, patients receive the same tests twice. That is why health reform improves communication and coordination among providers. Expensive diseases can be better managed if they are caught early, so health reform provides free preventive care.

Criminals try to rip off taxpayers. Health reform provides law enforcement new tools and resources to protect Medicare and Medicaid from fraud. I am pleased to hear that the administration's anti-fraud efforts have recovered more than \$4 billion just last year.

We know that some of the best ideas do not come out of Washington: they come from our own communities. That is why health reform created the Medicare and Medicaid Innovation Center to leverage these good ideas and partner with the private sector.

Secretary Sebelius, I am pleased to see that you are enlisting private sector partners. The recent innovation challenge has sparked thousands of ideas from the best providers our system has to offer, including some from my home State of Montana.

Never before has the need to reign in out-of-control health care costs been higher. Never before has a consensus for action been stronger. Madam Secretary, I urge you to continue to use these tools provided by the Health Reform Act.

The goals and responsibilities of your Department are broader than health care. Our Nation must revisit the ways we prevent poverty. Our economy has continued to recover, and I am pleased to see that the budget reflects that positive growth. But our work is far from complete. The human service programs we will work on this year present significant opportunities to build upon the strengths of the American family. We must find the best and most effective ways to help families in economic crisis.

Temporary Assistance to Needy Families must be maintained for the well-being of children and families facing dire circumstances. I was pleased to work with Senator Hatch and the many child welfare champions on this committee to reauthorize the Safe and Stable Families program last year. We should consider the lessons we learned and the principles that guided us during that process as we work to reform the entire child welfare system.

So let us improve these human service programs. Let us work together to strengthen Medicare and Medicaid. Let us make our health care system more efficient. Let us build on the health reform law. Let us heed President Eisenhower's warning that, unless we progress, we regress.

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

The CHAIRMAN. Senator Hatch?

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

Senator HATCH. Well, thank you, Mr. Chairman. It is a pleasure to work with you on this committee, and all of the other members of the committee. I want to thank you for scheduling this hearing today.

Secretary Sebelius, thank you for taking the time to be with us. We have a lot to talk about, since it has been over 300 days since you have testified before this committee which oversees much of your budget.

I suspect it comes as no surprise that our list of questions is long. The question that American taxpayers are asking is how the President proposes to balance the budget and how he intends to get our Nation's debt and entitlement spending under control.

After all, he promised when he was elected that he would cut the deficit in half by the end of his first term. Yet, with a fourth straight trillion-dollar deficit under the Nation's belt, the expiration date on that election-year promise has long passed.

I think many Americans would be willing to cut the President some slack if he demonstrated any willingness to lead us out of our debt crisis. But, with this budget, he again demonstrates that he would rather pursue his own political gain over fiscal stability. The budget completely fails to address the gathering storm of our entitlement crisis.

But do not take my word for it. Just look at what everyone from the *Washington Post* to the *Wall Street Journal* is saying about this

budget. We have a special chart here. According to the *Washington Post*, the budget begins with “a broken promise and omits all kinds of painful decisions.”

The assessment of *Business Week* is equally grim: “The budget does little to restrain growth in government’s huge health benefit programs.” The *Wall Street Journal*, I think, hits it on the head, concluding that “it is a brilliant piece of misdirection. Voters need to suspend disbelief for another 9 months.”

At the same time that the President cuts the defense budget and complains about the lack of spending on infrastructure, his budget ignores that entitlement spending is crowding out these priorities. Medicare, Medicaid, and Social Security will increase as a percentage of GDP from 9.7 percent to 11.2 percent over the next 10 years.

Federal Medicaid spending as a percentage of GDP will increase from 1.6 percent to 2.1 percent over the next decade. That is an astonishing 30-percent increase in the Federal portion of the program. Mandatory health spending under the President’s budget actually increases by \$72 billion, since the modest \$366 billion in savings over 10 years are wiped away by an undefined \$438 billion proposal to fix the physician payment formula.

I wish you could say that this budget contains smoke and mirrors, but it does not. It is, rather, a transparent abdication of any responsibility to fix the entitlement spending crisis. Medicare remains on a path toward bankruptcy, and with it senior impoverishment. Under the President’s baseline estimates, Medicare and Medicaid are projected to spend \$11.1 trillion over the next 10 years. This level of spending is simply not sustainable.

According to the 2011 Medicare Trustees Report, the Hospital Insurance Trust Fund has \$8.3 trillion in unfunded liabilities and is expected to be insolvent by 2024. Real choices, difficult choices are necessary, but the President refused to make them in his health law, and he refuses to make them now.

Astonishingly, the President’s comprehensive health law failed to address the sustainable growth rate formula which is used to determine payments for physicians, despite cutting \$529 billion from the Medicare program.

With respect to Medicaid, the budget baseline proposes spending \$4.37 trillion on the program over the next 10 years. This amount includes the health law’s new spending on the largest expansion of the Medicaid program since it was created in 1965. Furthermore, the budget fails to respond to repeated requests from Governors for any real flexibility to implement solutions that might work for their citizens.

For the third year in a row, the President’s budget proposes increased spending while failing to propose a financially responsible long-term authorization of the Temporary Assistance to Needy Families program, which will expire at the end of this month.

In his health law, the President famously promised to bend the cost curve with respect to health expenditures. He failed to do so with that law. With this budget, he has failed again. Over the next 10 years, total mandatory spending for Medicare and Medicaid will exceed \$11 trillion.

Now, we have another example, as shown on the chart. The President’s budget would only reduce that amount by \$366 billion

over 10 years. That is a trifling reduction of 3.6 percent over the next decade. Over the 75-year window, it translates into a rounding error, a reduction of one-half of 1 percent.

As insignificant as these spending reductions are, it has become clear that the President is not serious about achieving even them. He has suggested that, unless Congress adopts his tax schemes for wealth redistribution, any adjustment to entitlement spending is off limits.

The President's reelection advisors in Chicago might think that it is politically advantageous to hold entitlement reform hostage to his class warfare proposals, but it is fiscally irresponsible.

Again, thank you, Mr. Chairman. Secretary Sebelius, I look forward to a fruitful dialogue and look forward to chatting with you.

The CHAIRMAN. Thank you very much, Senator.

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

The CHAIRMAN. I would now like to turn to our honored guest and witness, Secretary Sebelius.

Madam Secretary, you know the drill. Your statement is automatically included in the record, and I urge you to tell us what you want. Be candid, be direct, and take your time. Not too much. [Laughter.]

I want to give you enough time so that you can say what you want to say.

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SEBELIUS. Well, thank you very much, Chairman Baucus, Senator Hatch, and members of the committee. I look forward to the opportunity to discuss the President's 2013 budget for the Department of Health and Human Services.

Our budget helps to create an American economy that is built to last by strengthening our Nation's health care, supporting research that will lead to tomorrow's treatments and cures, and promoting opportunity for America's children and families so everyone has a fair shot to reach their full potential.

It makes the investments we need right now to keep our economy going in the right direction, while reducing the deficit in the long term to make sure the programs that millions of Americans rely on will be there for generations to come.

Now, I look forward to our dialogue and answering questions about the budget, but first I want to just share some of the highlights. Over the last 2 years we have worked diligently to deliver the benefits of the Affordable Care Act to the American people. Thanks to that law, more than 2.5 million additional young Americans are already getting coverage through their parents' health plans. More than 25 million seniors have taken advantage of free recommended preventive services under Medicare, and small business owners are getting tax breaks on their health care bills to allow them to hire more employees.

This year we will continue to build on those important efforts by continuing to support States as they work to establish affordable insurance exchanges by 2014. Once these competitive marketplaces

are in place, they will ensure that all Americans have access to quality, affordable health coverage.

Because we know that a lack of insurance is not the only obstacle to care, our budget also invests in the health care workforce. The budget supports training more than 7,100 primary care providers and placing them in the parts of the country where they are needed the most.

It also invests in expanding the network of community health centers. Together with the 2012 resources, our budget will create more than 240 new access points for patient care along with thousands of new jobs. Altogether, health centers will provide access to quality care for 21 million Americans, 300,000 more than were served last year.

This budget also continues our administration's commitment to improving the quality and safety of care by spending health dollars more wisely. This means increasing our investments in health information technology and improving care for those who rely on both Medicare and Medicaid, the so-called dually eligible.

It also means funding the first-of-its-kind CMS Innovation Center, which is supporting and partnering with physicians, nurses, hospitals, and others who have accepted the challenge to develop a new, sustainable health care system.

In addition, the budget ensures that 21st-century America will continue to lead the world in biomedical research by maintaining funding for the world's leading researchers at the National Institutes of Health, and will support their work with an emphasis on outcomes research that compares the risks, benefits, and effectiveness of medical breakthroughs so we can get the biggest payoff possible for our research dollars.

This administration also recognizes that, in order for our country to succeed, we need to invest in tomorrow's scientists as well as tomorrow's teachers, engineers, doctors, and architects. But today, too many young children have their futures short-changed because they start school too far behind and never catch up.

We know that high-quality early education programs put children on a path to school success and to a lifetime of opportunity. High-quality early education does not just lead to higher test scores and graduation rates, it leads to more productive adults, stronger families, and more secure communities. That is why our budget increases funding to support the 962,000 children in Head Start and the 1.5 million children in federally funded childcare assistance programs.

Our investments will also support critical reforms in both Head Start and childcare programs to raise the bar on quality. This year for the first time we will require Head Start programs that do not meet important quality benchmarks to compete for funding. Our budget supports a new childcare quality initiative that allows States to invest directly in programs and teachers so that individual childcare programs do a better job of meeting the needs of children and their families.

Investing in health care, cutting-edge medical research, early childhood education, and other priorities that will help us create an American economy built to last requires resources. That means we

have to set priorities, make difficult trade-offs, and ensure that we use every dollar wisely.

Our budget does this, helping to reduce the deficit even while we invest in areas critical to our Nation's future. That starts with continued support for President Obama's historic push to stamp out waste, fraud, and abuse in our health care system.

Now, over the last 3 years, every dollar we have put into health care fraud and abuse control has returned more than \$7, a pretty good investment. Last year alone, those efforts recovered more than \$4 billion for American taxpayers.

Our budget will build on those efforts by giving law enforcement the technology and data to spot perpetrators early and prevent payments based on fraud from going out in the first place. The budget reflects the careful review we gave to every program, looking for opportunities to make them leaner and more effective. It includes some difficult cuts we would not have made if our Nation's fiscal health and tight budget times did not require them.

The budget also contains more than \$360 billion in health savings over 10 years, most of which come from reforms to Medicare and Medicaid. These are significant, but they are carefully crafted to protect beneficiaries. For example, we propose significant savings in Medicare by reducing drug costs, a plan that will put money back in the pockets of Medicare beneficiaries.

Our budget makes smart investments where they make the biggest impact and ensures millions of Americans will have access to the health care they need. It funds cutting-edge biomedical research, invests in our youngest children so they achieve their fullest potential, and it puts us all on a path to a stronger, healthier, and more prosperous America for the future.

Thank you again, Mr. Chairman and Senator Hatch. I look forward to our conversation.

[The prepared statement of Secretary Sebelius appears in the appendix.]

The CHAIRMAN. Thank you, Madam Secretary.

I would like to talk to you about two subjects. One is, how well is the innovation center doing? I noticed there are ideas like health coaches and expanding medical homes. I tend to believe that the innovation center and the funding for it is a good way to move us toward more efficient systems, but could you speak on just how that is progressing and what is working with the innovation center, what is not working, and what could be done to make it work better?

Secretary SEBELIUS. Well, thank you, Mr. Chairman. I think the innovation center is one of the great initiatives funded as part of the Affordable Care Act. It is really the research and development arm of our major health care initiatives.

In that way, about one-tenth of 1 percent of our overall health care spending is dedicated to finding the best new ideas that improve quality and lower costs, and they are in pockets around the country, but not taken to scale. So, medical homes for Medicare patients is a strategy that is tried someplace, and we are trying to improve it.

The Accountable Care Organizations are pioneers who are really way ahead of their time in coordinating care with doctors and hos-

pitals, with the kind of bundled payment strategy that makes sure when a patient is dismissed from a hospital that he or she is not on their own to figure out strategies of how that care can be improved and to prevent an unnecessary readmission.

We have some very exciting projects under way with States around the better care/better cost outcomes for the dually eligible, those Americans who qualify for both Medicare because of their age or disabilities, but also Medicaid because of their income, a fast-growing population but one that I think has significant care challenges.

So we are very excited about the investments made so far and about the strategies rolled out, and we think they have enormous potential, not only to reduce the costs and improve care in government programs, but to reduce costs and improve care for private sector payers.

Our Partnership for Patients is a great example. Reducing hospital-acquired infections, reducing preventable readmissions, not only helps the government programs, but certainly helps all our private sector partners, which is why we have more than 3,000 hospitals, as well as a lot of major employers, who are thrilled with this initiative and eager to step up and help us figure it out.

The CHAIRMAN. I appreciate that. I just urge you to maybe quantify results so that we know we are being efficient with the various innovations.

Turning now to exchanges. I see you asked for more money for the exchanges that go into effect in 2014. How many States do you think will have exchanges operating by themselves, how many not? What are some of the worries? What is some of the good news, but what are some of your concerns about the exchanges? The other question tied to that is, how many employers do you think are going to drop coverage to the exchanges because it is cheaper for them to pay a penalty than it is to provide health insurance, thinking, well, the exchange is there; that will take care of it.

Secretary SEBELIUS. Well, Mr. Chairman, we are actively working with States across the country and have engaged, I think, 48 States in a variety of programs, from planning grants, to implementation grants, strategies that they are putting in place a step at a time.

Right now, I think it is impossible to tell you exactly how many States will have a State-based exchange, how many States will be in a so-called partnership effort where they will begin by running parts of the program at the State level—the Federal program—in their build toward a fully functional State exchange sometime after 2014.

What I am confident about is that we will begin enrolling individuals across the country in exchange programs in the fall of 2013 so that they can be fully covered by 2014. I think States are in a variety of conditions of engagement at this point.

In terms of dropping coverage, again, the only real-life example we have in terms of this sort of framework being in place is the State of Massachusetts, which has a very similar structure for employers, a penalty if people do not carry insurance, and the availability of an exchange.

We found in the State of Massachusetts that actually covered increased, it did not decrease, when the exchanges were fully functional. I think if you talk to business leaders, they will tell you that providing affordable insurance coverage is not only a cost factor, but it is a way to keep and maintain the best possible employees, to recruit employees.

It is a strategy that employers are eager to engage in, but often cannot afford. So having a structure, particularly for smaller employers, I think will encourage them to stay in the marketplace. We are already seeing a number of small employers who left the marketplace take advantage of the tax credits available for employee coverage, and I think that is an encouraging sign.

So we have asked for additional resources, and that is really to focus on the functions of the Federal exchange, which we will be setting up. Many of those are one-time expenditures for an infrastructure and IT system.

The CHAIRMAN. I appreciate that. Thank you very much.

Senator Hatch?

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

Secretary Sebelius, we are glad to have you here and are pleased that you are with us.

Now, regarding the contraceptive mandate, I am going to ask you questions that I think require only a “yes” or “no” answer, and we will get through this more quickly, and hopefully I will not have to do it in subsequent rounds.

Regarding the contraceptive mandate that has raised such significant religious freedom concerns, I want to make crystal clear what mandate is actually enforced today. Now, those religious freedom concerns have been directed at the amendments to the interim final rule issued last August. Last Friday you finalized those rules, as I understand it. I have that final rule right here. It states that you finalized those very same controversial proposed regulations “without change.” Is that correct?

Secretary SEBELIUS. We finalized the IFR with an additional delay period for those religious employers who find objection to offering contraception, and there they will have a year delay in implementation so we can work out a strategy where they can abide by their religious freedom and the women employed in those institutions will have contraception.

Senator HATCH. Yes. My point is, it is still the same directive but subject to having a year hopefully where you can negotiate the changes that might need to be made. Is that fair?

Secretary SEBELIUS. The waiver language is as it appeared in the original rule in August, with the exception that religious employers will not purchase, will not provide, and will not offer, if they object, contraceptives directly to their employees. But the employees in those religiously based facilities will have access to that care with no additional co-pays or no co-insurance.

Senator HATCH. I have a copy of it here. It says, “These regulations finalized without change; interim final regulations authorizing the exemption of group health plans and group health insurance coverage sponsored by certain religious employers from having to cover certain preventive health services under provisions of the Patient Protection and Affordable Care Act.”

Then also it states in here, in other words, we are currently operating under the same language that was objected to by some in the religious community. It also says, "The departments have determined that it is appropriate to finalize, without change, these amended interim final regulations authorizing the exemption of group health plans and health insurance coverage," et cetera.

Secretary SEBELIUS. Senator Hatch, we announced that we will be promulgating an additional rule dealing with the religious employers who currently do not offer contraceptive coverage because of religious beliefs and that that rule will be in place and effective by August of 2013, when the IFR would apply across the board.

Senator HATCH. All right.

In his statement on Friday addressing the supposed compromise on this mandate, President Obama said, "From the very beginning of this process I spoke directly to various Catholic officials."

Now, prior to Friday, February 10, did you consult with any individual Catholic bishop or the U.S. Conference of Catholic Bishops about this so-called compromise?

Secretary SEBELIUS. I did not speak to the Catholic bishops.

Senator HATCH. All right. That is all I wanted to know.

To your knowledge, prior to Friday, February 10, did anyone in the administration—anyone in the administration—consult with any individual Catholic bishop or the USCCB about that so-called compromise, to your knowledge?

Secretary SEBELIUS. I know that the President has spoken to the bishops on several occasions, yes.

Senator HATCH. Was it about that so-called compromise?

Secretary SEBELIUS. I—I—

Senator HATCH. You do not know?

Secretary SEBELIUS. I really do not know.

Senator HATCH. All right.

Are you aware of any consultation, prior to Friday, February 10, by anyone in the administration, the President's reelection campaign, or the Democratic National Committee, with any person affiliated with Planned Parenthood of America, NARAL, or the ACLU about the so-called compromise?

Secretary SEBELIUS. Again, Senator, I know numerous conversations were had with religious leaders, with employers, with insurers, and with stakeholders.

Senator HATCH. And with these groups as well?

Secretary SEBELIUS. Pardon me?

Senator HATCH. With these groups as well?

Secretary SEBELIUS. I assume some of those groups were talked to. I really have no idea if anybody in the administration talked to anyone.

Senator HATCH. All right.

I wrote you last July that your proposed contraceptive mandate would be "an affront to the natural rights to life, religious liberty, and personal conscience." I note for the record that your response to my letter completely ignored this issue.

Last October, 27 Senators joined me in writing you again, asking for any analysis requested or obtained by HHS regarding these religious liberty issues. The response from your Department completely ignored our request. There were 27 of us who asked for it.

The President's Chief of Staff and Press Secretary have since claimed that this mandate is consistent with the First Amendment, and the final rule you issued last Friday states that it is consistent with the First Amendment and the Religious Freedom Restoration Act, which is the bill that I brought to the Congress.

Let me just ask you again, did HHS conduct or request any analysis of the constitutional or statutory religious freedom issues?

Secretary SEBELIUS. Senator, I think—

Senator HATCH. If you know.

Secretary SEBELIUS [continuing]. What you heard was the President talk about two important principles, the availability of preventive health services—

Senator HATCH. No. My question was—

Secretary SEBELIUS [continuing]. To women and religious freedom.

Senator HATCH. My question is a simple question. Did you or anybody at HHS conduct or request any analysis of the constitutional or statutory religious freedom issues? That is a simple question.

Secretary SEBELIUS. Well, we certainly had our legal department look at a whole host of legal issues and I—

Senator HATCH. Did you ask the Justice Department?

Secretary SEBELIUS. I did not. No, sir.

Senator HATCH. All right. All right. That is all I want to get.

Well, my time is up. Next, will be Senator Bingaman.

Senator BINGAMAN. Thank you, Mr. Chairman.

Madam Secretary, thank you for being here. Let me just say for the record I appreciate the reasonable position that you have arrived at with regard to contraceptive services. I think it adequately protects religious liberty and at the same time protects the right of women to obtain contraceptive services when they choose to. So, that is a different perspective than the one Senator Hatch was expressing.

Let me ask you about a provision in the Affordable Care Act that relates to our workforce, our health care workforce. We put a provision in there that I felt was very important. It created a new, independent, and nonpartisan National Workforce Commission. The commission is tasked to provide Congress and the administration with information and guidance on how we can align our Federal resources to meet the health care workforce needs of the Nation.

This resulted from the recommendation by the Institute of Medicine and was modeled after MedPAC, this commission is. The commission was strongly supported by Senator Baucus, Senator Murray, myself, and many others. It is my understanding that commission members were selected by the GAO in September of 2010, which is nearly 18 months ago, but they have not been able to work because they have not had any funding.

Now, I think there is some provision in this budget to provide initial funding, and I just wondered if you could give us an update as to what can be expected. Is this commission going to be allowed to proceed to do its work, and when?

Secretary SEBELIUS. Well, Senator, I share your interest in the work of, not only this commission, but the necessary work that needs to be done looking at the entire health care workforce.

Whether or not we had an Affordable Care Act, we have some workforce challenges as America ages, and, as we look at a misalignment of where the health care providers are and where the people are, it does not often match. So we have been working on this from day one.

As you know, the Recovery Act provided some resources, the Affordable Care Act continued those resources: more training, more graduate medical education, more shifts in focus. We are eager to have the appropriations to get the commission up and running. We think that is an important advisory group and an important piece of the puzzle.

We have been using internal resources with our planning and evaluation staff, our Agency on Health Resources Service Administration, which deals a lot with the workforce issue, with CMS, to look at all the levers we currently have and all the analysis we can do about what is projected to be needed in the future and what ways we have it moving in that direction. But I am hopeful that we can work with Congress to get the commission fully funded and operational.

Senator BINGAMAN. Well, I will continue to communicate with you on this. I think this is a very low-cost item in the broad perspective of our health care delivery system, but I think it is an important one.

Let me ask about the health insurance exchanges that Senator Baucus asked you about. One concern I have had is that, in our zeal to be sure that States can do whatever they want by way of establishing these health insurance exchanges—or do it the way they want, I should say—I am concerned that the underlying IT systems that are being developed State by State by State are not going to be able to communicate with each other. They will not have the common elements that they need to really have good information for us nationally on what is going on here.

I know our State is spending a big chunk of the money that you have provided in the planning grant to work on an IT system. I know every State in the country is spending a big chunk of the money that is being provided to them, working on the IT system. Is there something that you are doing to ensure that we do not just have everyone inventing the wheel in every State of the Union here?

Secretary SEBELIUS. Yes, Senator. I think your concern is well-placed and well-founded. We did early on release some early innovator grants specifically for IT systems so that States who were frankly already well under way creating a health-wide IT system could actually move ahead of the pack and share what they were learning with other States to sort of reduce the reinvention of the wheel over and over again.

We also have resources going to States so that they can look at a more comprehensive approach for consumer ease and availability so a consumer does not have to figure out where he or she might fit if they are Medicare-eligible, if their kids are eligible for the children's insurance program, if someone is eligible for the exchange or a tax credit for the exchange, but that the system indeed encourages that.

So there was some, again, early IT money to look at a more comprehensive approach. We are certainly gathering States on a regular basis to share with one another what are the templates, what are the effective strategies, what is already in place, what this looks like, to try to minimize people having to start all over again and to accelerate their progress toward an effective exchange IT system that works.

Senator HATCH. Senator Cornyn?

Senator CORNYN. Thank you, Madam Secretary. We are having a little bit of a shuffling here, but we will get through this.

I note that the rate of uninsured in the country was at 17.1 percent in 2011, which is up about 7 percent over 2010, and even more than that from 2008. One of the reasons given for the increased number of uninsured is the number of individuals losing employer-provided coverage.

The Congressional Budget Office originally estimated that only some 7 percent of employees would lose their employer-provided coverage as the health insurance exchanges were implemented in 2010. McKinsey, the business consulting group, has estimated that at minimum somewhere on the order of 30 percent of employees would lose their employer-provided coverage, and it could well be as high as 50 to 60 percent.

Indeed, I think it is easy to see why that is true, because the financial incentives for an employer would create a reason for them to drop their employee coverage and to then require those individual employees to seek their coverage in the health insurance exchanges.

Of course, the employer-provided coverage is subsidized as a fringe benefit by the employer, not by the American taxpayer. But once they go into the exchanges, those individuals will be eligible for taxpayer-provided subsidies in the exchanges.

Can you tell us how the President's budget deals with this issue and how we are going to be able to afford to provide taxpayer-provided subsidies for this 50 or 60 percent of employees who are now provided with employer coverage?

Secretary SEBELIUS. Well, Senator, I think a couple of things. The economy certainly has a lot to do with employer coverage being lost, but I would also suggest that every analysis that I have read suggests that the extremely high cost and often lack of choice for small employers is also a driver in this marketplace where people are dropping coverage, particularly in the small marketplace. Large employers are keeping their coverage, small employers and individuals are often dropping coverage, and then people in the recession have lost coverage.

So the availability of State-based insurance exchanges in every part of the country, with competition—and by every Congressional Budget Office and every analyst's estimate—significantly lowers premiums based on a reduction of administrative overhead, pre-negotiation, and kind of an active purchaser role, which, I think, again means that people will be coming back into the marketplace.

I cannot speculate on what it is that people are looking at. What we know on the ground is that the only State with a fully operational exchange with a very similar framework is the State of Massachusetts. Employers did not drop coverage in that State.

They did not choose to exit the marketplace. In fact, more came into the marketplace. They have a higher rate of employer coverage right now than they did prior to the exchanges being set up, with a very similar kind of framework with a penalty and a tax subsidy.

Finally, Senator, the issue of subsidies—employer coverage is subsidized by American taxpayers. They are part of a business expense. It is why some individuals are, in this current market, not in as advantageous a situation. Again, with an exchange, individuals, entrepreneurs, those who set up their own business operations, would be able to participate in a much larger pool, with much more competitive rates once the insurance exchanges are operational.

Senator CORNYN. Madam Secretary, it seems to me that the economics for the employer are pretty clear, that rather than provide whatever the figure is, a \$10,000, \$8,000, \$6,000 insurance policy for an employee, that it is cheaper for the employer to drop that coverage and to force the employee then to go to the insurance exchange. They save much more than the tax deduction. That is an out-of-pocket cost.

So it seems to me that the administration has grossly underestimated the number of employers that will drop their employees from coverage, and indeed costs will explode far beyond the 7 percent that CBO projected on the bill.

Thus, it seems to me impossible for the President to keep his promise that, if you like what you have you can keep it, because the way the so-called Affordable Care Act, which I think in truth will become the unaffordable care act, is structured, it provides the incentives to drop people and cause them to lose their employer-provided coverage.

Secretary SEBELIUS. Well, Senator, right now I would just say the market is entirely voluntary, and what we find is that employers find it to be an enormous benefit to have affordable, robust health coverage for their employees.

One of the issues I hear from small business owners constantly is they are frustrated by having their best employees go down the street or around the corner or down the block, because that is by far the most important benefit.

So I think there are issues above and beyond cost, and I think, if the system is more cost-effective, if we are successful in changing some of the delivery system costs, lowering overall costs for both private sector and public sector, there is enormous benefit that lies ahead with full implementation of the ACA.

Senator HATCH. Senator Wyden is next, but he has graciously agreed to allow Senator Roberts to ask one question so he can get to his Agriculture Committee, and then we will go to Senator Wyden immediately following, then Senator Coburn after that.

Senator ROBERTS. I thank the ranking member or the vice chair. I apologize to my colleagues for breaking ranks; I think you are accustomed to that anyway.

Madam Secretary—nice to see you, Kathleen.

You have been to Children's Mercy. You have been a strong supporter when you were Governor. I really appreciate that. In Kansas City, they received the Children's Hospital Graduate Medical Education funding. I think a large percentage—I believe the number

that was quoted to me was 80 percent—of the doctors in this hospital that trains with these dollars stays in the surrounding area, which is obviously a very good thing.

My question is, the recipient hospitals are training more than 5,600 full-time equivalent residents per year. If we do not adequately fund this program, how on earth are we going to fill the gap that that creates in the pediatric workforce pipeline? I am a little worried about the funding level there for this program, which I think is exceedingly important.

Secretary SEBELIUS. Well, Senator, you are absolutely right. I think that children's hospitals, not only in the Kansas City area but around the country, do not only a great job on training pediatric residents, but on care delivery.

As we look at, again, the workforce of the future, I think the focus in our Department is on trying to maintain residency slots as much as possible, and training for primary care, which clearly includes pediatrics. In a better budget time, I think these numbers would be significantly higher.

We are trying to balance how to drive more dollars in teaching hospitals to primary care, gerontology, pediatrics, and look at all the sources of the levers. So you are right, the funding is not what we wish it would be, but we are going to continue to work with hospitals like Children's Mercy to make sure that they can do the great job that they are doing.

Senator ROBERTS. I look forward to working with you on that.

Secretary SEBELIUS. Thank you.

Senator ROBERTS. Mr. Chairman, thank you. I apologize again to my fellow colleagues.

Senator HATCH. Thank you, Senator Roberts.

One thing I would just like to establish. When can we expect an answer to our letter that the 28 of us wrote to you with regard to legal analysis on this freedom of religion issue? Can you answer that letter?

Secretary SEBELIUS. Senator, I do not know where the letter is at this point in clearance.

Senator HATCH. Well, we will get you one.

Secretary SEBELIUS. But I will try to respond as rapidly as we possibly can.

Senator HATCH. If you will do that, I would be very grateful.

Secretary SEBELIUS. Yes. Certainly.

Senator HATCH. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Welcome, Madam Secretary.

Madam Secretary, as you know, in our part of the country we have a lot of good-quality Medicare Advantage plans. You have plans, for example, like Group Health in Seattle, that are so popular. All the single-payer folks always tell me, whatever you do, just make sure you protect Group Health.

So I was particularly interested in the numbers you all have put together that indicate that in the last year—and this is country-wide, not just in the Pacific Northwest—Medicare Advantage enrollment has increased 10 percent, while premiums have fallen about 7 percent.

Now, this is particularly noteworthy, given all the predictions that came up during health reform. What do you think is behind a trend that indisputably seems pretty encouraging?

Secretary SEBELIUS. Well, I think, Senator, it is very encouraging. The 7 percent is—again, the decrease in premiums is a national average. In some places it is significantly higher. And over and above that, I think we are at 99.7 percent of Medicare beneficiaries who have a choice. There are only a very few isolated areas where there is not currently a Medicare Advantage plan in operation.

So I think it is a combination of strategies that were really part of the Affordable Care Act to negotiate for health benefits and look very carefully at pricing strategies, indicating to individuals for the first time we have a quality rating system. And what we are seeing is beneficiaries beginning to make substantial changes on their own based on the quality of those plans. In this case I think competition is paying off.

But with an announcement that the Medicare Advantage plans on average were being paid about 12 percent more than fee-for-service Medicare with no resulting health benefits, I think the market is adjusting to the notion that that payment strategy is coming down.

Senator WYDEN. Let me ask you about one other area, Madam Secretary. I always like to do the positive news first. This other area is not so positive, and it is the question of drug shortages. Yesterday I talked to a father of a 3-year-old in Oregon, and the 3-year-old has leukemia. The family cannot get their leukemia drug through their insurer.

Now, the Finance Committee held an important hearing on this topic. Chairman Baucus and Senator Hatch have been very interested in this drug shortage issue. We were told that, in effect, when the government sees that there is a drug shortage—this was the testimony we heard in the Finance Committee—it usually takes a year or longer in order to get the drug out again.

That is too late for many parents. These parents, like the family I talked to yesterday, say the government ought to have resolved this yesterday, and why can the government not fix this and stop playing catch-up ball?

The President issued an executive order on this last fall, and my question to you is: What specifically since then has changed so that the government is going to get out in front of this urgent problem? I am not the only member of the Senate who is hearing from parents.

I want to know what I can tell that parent when I call him back tonight. I said I was going to call him back tonight and say that I spoke to the government's point person on this issue. What can we tell that parent tonight that the government is doing to get out in front of this urgent issue?

Secretary SEBELIUS. Well, the good news for the parents of the child with leukemia is that the FDA did announce yesterday that they feel that in the next 2 weeks the leukemia drug shortage will indeed be resolved. People were afraid they were going to run out of the drug in 2 weeks. It is resolved because what we can do at the FDA is accelerate alternatives if we have notification.

What we know is that, since the executive order that the President issued in October, there have been over 200 shortages that actually have been averted. Because the FDA was notified, they can look for alternative sources of the drugs, they can expedite manufacturing lines in other areas. This really is, though, Senator, unfortunately a bit of a market glitch where the market capacity for drugs has not increased. There are pipeline increases that are 2 and 3 years off, but currently we have the same manufacturing capacity and drug marketers choosing which line of drug to produce at which time.

The earlier we are notified—and you have a bill pending in both the House and the Senate that we would be eager to work with you on. We have done as much as we can administratively, but a mandatory notification of drugs that appear to be getting to a shortage gives us then the ability to put our team into gear, and we can be fairly effective in at least finding alternative strategies, trying to ramp up other lines, putting pressure on groups, looking in Europe and Asia for an alternative. But if we do not know that it is coming, there is almost nothing the government can do.

Senator WYDEN. Mr. Chairman, I know my time has expired. I would only say, Madam Secretary, I do not think notification alone is going to do it. I think this is a question of what kind of incentives we need to get to manufacturers. I think it is a question of the grey market. Just notifying people about what everybody already knows, I just do not think that is going to do it. The chairman has been gracious in terms of his time. I will continue this with you because—

Secretary SEBELIUS. Well, Senator, we would love to work with you on this. I would say that notification is a huge piece of it. It may be one of the few pieces that we at the government can control. Again, looking at the market, which we have done extensively, the manufacturing capacity needs to be increased, and a number of the major pharmaceutical companies are in the process of doing that. They are just a bit behind the demand.

Senator WYDEN. I think the government has been behind.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Coburn?

Senator COBURN. Thank you, Madam Secretary. I appreciate your being here.

I have two areas that I want to discuss with you. One, in your testimony you talked about saving \$7 for every \$1 you put into fraud prevention. You came up with a number of \$4 billion. The outside estimates, as well as GAO, estimate improper payments to be over \$59 billion a year, and fraud in Medicaid and Medicare somewhere close to \$100 billion a year. So we are at 4 percent.

My question is, you all signed a contract for \$77 million on a cost-plus basis with three firms that have never done what you are asking them to do. At the same time, another firm that has done this for 70 percent of all the insurance companies in this country in terms of predictive payment and whether or not to pay or whether to look, offered to do this for free for the government.

Now, I understand the government cannot take free services, but it is concerning to me that we would go with three contractors that have absolutely no experience to set up something that could im-

mediately save us billions of dollars and not contract with the one firm that actually has real experience in doing that. Can you explain that to me?

Secretary SEBELIUS. Senator, I have to confess, I am not aware of the contracting negotiations or who bid, or what the decision was. I would be very pleased to get that answer to you in detail and have Dr. Peter Budetti, who is the first person at Medicare and Medicaid to ever focus on fraud—we have a senior leader who is charged with doing that, building the predictive modeling, but I will get you a very detailed answer.

Senator COBURN. I understand that. We have had him in front of our committee, and his answers were not satisfactory on that as well. So the question is, we have a cost-plus contract, \$77 million, getting ready to expire—we are going to renew it—on the performance criteria for you all to effectively manage what you are doing.

You chose somebody who has never done it before and refused to use the company that offered to do it for free, which was IBM, which has the vast experience in this world in terms of predictive modeling. To me, it makes no sense. It is no wonder that the people in this country do not have any confidence in us when we do not have the common sense to utilize things that are available to us.

The second point that I want to go to is, in the Affordable Care Act there was a nice little trick that enhances Massachusetts to the tune of \$3.5 billion over the next 10 years at the expense of 48 other States by what they did with a trick with one hospital, one rural hospital, converting one hospital in the most expensive place to live in Massachusetts to a rural hospital, thereby upgrading the wage valuations for the rest of the hospitals in Massachusetts.

You all had the opportunity to either do that or not do that. Why is it that you have decided that we should go ahead and do that and decrease the reimbursements? For the members of this committee, it is going to cost you \$280 million a year for your hospitals, because that is going to be going to Massachusetts on the basis of one gimmick in the Affordable Care Act.

Secretary SEBELIUS. I am sorry, Senator. I am trying to get the details of the Act. When you say we had the ability to do it or not do it, I am trying to understand what it is that—

Senator COBURN. You had the ability to grant that waiver or not grant that waiver back to a rural hospital status. You did not have to. You could have said, no, that will disrupt the payments to the rest of the hospitals throughout the country. But you chose to do it anyway.

So the question is—we are going to take \$3.5 billion out of the hospitals from all the rest of the States and transfer it to the highest-cost State there is, and on the evaluations in the future, in terms of the labor wage rates, we are going to protect Massachusetts on the basis of that, and every other State is going to have a different determination because of how we are going to value their inputs in the future.

The question is, why should one State have the advantage over all the rest of the States for reimbursements that are markedly higher than for everybody else, and all the other hospitals have to pay for it throughout the country?

Secretary SEBELIUS. Well, again, Senator, I will take a look at that specific provision. I know that part of the requirements of the Affordable Care Act are two different studies on wage analysis that will be—one is under way. I think the second one is about to be started. We are directed to not only report back to Congress, but to actually reevaluate the entire CMS wage basis based on that market analysis. So, this will be part of that overall look. If it was directed as part of the Affordable Care Act, it is not something our Department executed, it was part of the legal requirements. But let me make sure I understand what you are talking about.

Senator COBURN. Well, the way I read it, you had the opportunity as to whether you were going to grant them rural status or not, and you chose to do that.

Secretary SEBELIUS. If it was directed as part of the Affordable Care Act, we did not.

Senator COBURN. No. Well, you—

Secretary SEBELIUS. I need to—

Senator COBURN. Certain delegations have written to you, asking to make sure you maintain what your decision was, so you obviously had a decision or they would not be writing to you. I have a copy. I would be happy to put the letter in the record. I know you know what it is, and I would ask that this be part of the record.

The CHAIRMAN. Without objection.

[The letter appears in the appendix on p. 33.]

Senator COBURN. But the point is, when we advantage certain people through legislation, that is exactly what America is sick of, this insider trading, the real insider trading, where we cheat the hospitals of 48 other States to advantage one group. It is inappropriate, it is not fair, and it does not do anything in the long run for the better aspects of medicine.

I yield back.

The CHAIRMAN. Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman. Thank you, Madam Secretary, for your service.

I have three questions, so I would like to put the questions out there first and then see your responses. They all deal with elements of the Affordable Care Act, which I supported. Some of these are particularly of great interest to me and to many people in the country who would advantage themselves on what these provisions in the Act would do.

One is, in the law we ensured all qualified health plans would include behavioral health services as part of the essential health benefits package. Among the universe of those who would receive those benefits, of course, are those who have families in the autism spectrum. New Jersey has the highest autism rate in the Nation, unfortunately, so I have heard these stories very vividly. Yet, they are unable to access vital behavioral health services.

Even in States with an autism coverage mandate, there are a number of exemptions that lead people to fall through the cracks. The language in the law, the Affordable Care Act, is specifically designed to address their needs and ensure that all qualified health plans will provide the benefits so many families need.

I am concerned that HHS's recent bulletin on the essential health benefits package refers to States using a benchmark plan as the basis for the essential health benefits package, but, because of the current patchwork of State autism coverage requirements and exemptions, I know I am not alone in the serious concerns that the benchmarking plan is insufficient to ensure that behavioral health coverage would be available on all qualified health plans, as the law dictates it should be.

So one, can you please explain what steps HHS is going to take to ensure plans will provide behavioral health services, as required by the law, and how will the process move forward on finalizing the essential health benefits rule? That is my first question.

The second question is with reference to a provision of the law that I previously introduced called The Mothers Act. It focuses on the devastating disease of postpartum depression. The language in the law required that HHS submit a report to Congress specifically addressing the benefits associated with screening for postpartum depression, and this report is supposed to be due within 2 years after enactment, which would be March 23.

So I would like to get a sense of how that report is coming along, when we can expect to see it, if you know what the report is going to say, what findings does it have as it relates to this issue.

Lastly, New Jersey currently has an 1115 demonstration waiver application pending before CMS. These waivers can be comprehensive. They involve major structural changes to a State's Medicaid program, affecting hundreds of thousands of the State's most vulnerable residents.

New Jersey's application was submitted in September of last year, and rumor has it that it may be approved as soon as this weekend. I say "rumor" because this entire process—I have to be honest with you—goes on behind closed doors without public notice, certainly without public input. My understanding is the law requires a process that is more transparent, and the rules on that have not been finalized.

I have to say, as a member of the committee with jurisdiction over the Medicaid program and as a Senator, it is more than frustrating to be shut out of a discussion affecting not only Medicaid beneficiaries in my State, but institutional providers such as hospitals, skilled nursing facilities, and home health care providers.

So, if the law was meant to be transparent, and a member of the Finance Committee and a U.S. Senator cannot get information about the process, which is what we are constantly being told by CMS, something is wrong with that process.

Secretary SEBELIUS. Well, Senator, let me see if I can address your concerns. The essential health benefit model that we chose to adopt is the so-called benchmark model, which would allow a State to use a popular employer coverage or State employee coverage or the Federal employee coverage existing as a benchmark.

But all of the rules of the ACA apply, including the 10 categories of mandatory coverage, so none of that is waived as you look at a benchmark for a particular State. I would say that we tried to balance affordability with comprehensive coverage in order to get a State up and running.

What we found, looking at the models across the country, is that there was very little variation in the actual coverage. There was a lot of variation in cost-sharing. That seemed to be the most significant in the categories.

But the anti-discrimination, the ability of a plan to weight one category and so disadvantage behavioral health and say we are looking at 9 of the 10, but we are going to be very skimpy on behavioral health, those rules all are imposed on top of the benchmark strategy.

So we will be working very closely with States to make sure that—as you know, behavioral health is one of those critical categories of care that is an underlying premise for what has to be in every essential health benefit, but we need to make sure that is in place, not only in New Jersey, but around the country.

But we wanted to kind of take advantage of plans that were in the market, were purchased, were priced, and could be up and running as we start this process. We will continually reevaluate and make sure that there are not benefits that are being overlooked or skipped along the way.

The Mothers Act provisions are definitely under way at the National Institute of Mental Health, looking at postpartum depression studies. They have 60 different grants on the issue, two program announcements, and we will be reporting back.

I cannot tell you right now what exactly that is going to say, because I have not seen the draft of the report, but we will make sure, Senator, to get you the various clinical research that has been going on, the risk factors, the neuroscience that they are taking a look at, and make sure that your concerns about this very important area are addressed when we come back with this study.

The CHAIRMAN. Senator Snowe?

Senator MENENDEZ. Can I get the third answer?

The CHAIRMAN. Yes. All right. We are a little over time here. Go ahead. Finish.

Senator MENENDEZ. My questions were within time. The answers are—

The CHAIRMAN. But still. I am not going to get into that debate. But anyway, go ahead. Finish it. Finish it, Madam Secretary.

Secretary SEBELIUS. Again, you are absolutely right that new rules, when they are in place, will require a far more robust process with 1115 waivers, having, at the State level, an opportunity for comment. The current rule really is the Governor and the State negotiates with our Department. We are not, by practice and statute, able to share those negotiations.

The Governor's office could share. But as far as I know, there is no imminent—I, in fact, speak to the Governor this afternoon. There is not any imminent waiver decision. But I understand what you are saying. We hope to get to the point where this is a much more transparent process in the very near future.

The CHAIRMAN. Thank you.

Senator Snowe?

Senator SNOWE. Yes. Thank you, Mr. Chairman. Welcome, Madam Secretary.

The first question I have is in two areas, one in LIHEAP, the low-income home energy assistance program, and the other in the Medicaid program.

First of all, I was just truly surprised and disappointed that the President's proposed budget for the next year advances another major reduction in low-income fuel assistance by almost half a billion dollars in addition to the proposed cut last year that was almost \$1.2 billion—\$2.2 billion actually, and the Congress restored \$1 billion of that. I mean, this is historically low assistance for the needy population, certainly in cold weather States. I mean, the *New York Times* did a front-page story just a couple of weeks ago on the dire, desperate circumstances so many people face, including in this instance where the individual offered his car as collateral to pay for assistance.

Maine has gone, during the President's administration, from \$80 million to a proposed \$32 million with this additional cut. I just do not understand it, given the significant increase in the price of oil, which is now close to \$3.80; for propane, it is over \$4. The average person requires an average of 850 gallons. That is devastating.

In fact, I talked to one woman. She and her husband both lost their jobs; they have three children. One child contracted pneumonia because they had no heat in their house. Why is the President proposing cuts in this program when there were \$7 billion in cuts in discretionary spending in the final omnibus bill, yet \$1.2 billion of that \$7 billion ended up being in the low-income fuel assistance program?

Secretary SEBELIUS. Well, Senator, I understand your concerns, and certainly the States where heating oil is the primary heat, it is particularly dire. I would say this budget is half a billion dollars above the President's request in last year's budget. I know that is not much solace as you look back on the last several years. Again, in a better budget time this request would be far more substantial, but it is an increase over what was requested last year, and I do understand your concerns.

Senator SNOWE. Well, I appreciate that. But in your budget of \$70 billion, I would hope that we could find a place for people who earn \$16,000 and have to pay \$2,500 to \$3,000 for an oil bill. I am just telling you, the circumstances are horrific, and I would hope that the President and you could find someplace—I mean, really, this program has really taken a heavy hit.

On the second question on Medicaid—and I know this has been much discussed—many States, including mine, are wrestling with some major challenges. When we were debating the health care bill here in the Finance Committee, Senator Grassley and I were able to include some flexibility in the maintenance of effort to bring it down for parents and childless adults, down to 133 percent of the poverty level.

Maine happens to have one of the top 5 most generous programs in the country for parents. The point is, as you know, States are grappling with deficits. That is what our amendment was all about, to give them flexibility in the event of budget deficits. That has been Maine's circumstance.

You had written to the Governors back in February of last year that you were committed to responsiveness and flexibility to expe-

dite review of State proposals to address some of these problems in Medicaid.

In addition, the Medicaid Director, Cindy Mann, had suggested in your Department “reductions in eligibility solely for budgetary purposes would not be experimental, pilot, or demonstration projects.” There is obviously a concern what authority you have and what you do not. I think the point here is, we want to avoid reductions in eligibility and to continue with the eligible population having coverage, but to also avert Hobson’s choices.

Like in Maine, for example, eliminating optional benefits like waiting lists for those who are developmentally disabled. What can you offer to States like Maine so that we would avert and avoid those types of choices, but address some of the budgetary issues that they are facing that could provide short-term savings now?

Secretary SEBELIUS. Well, Senator, I had a conversation with your Governor, I think, in the last 2 weeks about this very issue. We, again, made it clear to him what was within the State’s discretion, and some of the provisions that you have just outlined.

Senator SNOWE. Right.

Secretary SEBELIUS. The adults down to 133 percent—that is a choice they could make right away. We volunteered to send a team in to look at their other choices. We did not have a lot of paper from the Governor about what exactly was the proposal but committed to doing whatever we could to look at ways that, not only they could make immediate changes in areas where they had administrative flexibility and we would identify them a category at a time, but then look at ways that hopefully we could help reduce the costs in categories where we do not have a lot of flexibility. But we are waiting to get some responsiveness, and we are doing that with States across the country.

Senator SNOWE. Good. Well, I think it would be helpful if we could, going forward, find models that work. I know the areas you identified, about five areas, to the National Governors Association, where they could find short-term savings.

But I am just wondering if we could go beyond that and figure out what can work within the constraints. Even with the constraints of maintenance of effort, continuing with the eligible population, are there ways and models and demonstration programs that could be used effectively to actually work to achieve savings and help deliver these programs and services more efficiently?

Secretary SEBELIUS. And we are eager to do that. Dan Crippen, the new head of the National Governors Association, the former head of the Congressional Budget Office, was in my office yesterday, and we talked about the fact that there was a new class of Governors in 2010, 19 new Governors. While I met with, I think, each and every one of them, a number of them are facing lots of incoming, and it is very difficult.

What we want to do is go back around and have those conversations in great detail. We have lots of Governors now participating in this effort on dual-eligibles, which is one of the most expensive populations that any State has in their Medicaid budget. Frankly, moms and kids are fairly inexpensive to cover. Disabled, elderly, poor with multiple chronic diseases are often very, very challenging, not only in terms of care, but in terms of costs. So we are

working closely, and we want to get those good strategies and ideas to everybody. I would be happy to work with your office and keep you updated.

Senator SNOWE. Yes. And if there is anything that we can do to help in that process—

Secretary SEBELIUS. Yes. Thank you.

Senator SNOWE. Because I think then it sort of becomes a win-win. It becomes collaborative rather than adversarial—

Secretary SEBELIUS. Yes.

Senator SNOWE [continuing]. Making some tough choices that affect people.

Secretary SEBELIUS. You bet.

Senator SNOWE. Thank you.

Senator HATCH. Senator Grassley?

Senator GRASSLEY. I only have a couple of questions. Before I do that, I want to associate myself with the remarks made by my colleagues about the so-called contraceptive rule. I think you got it very wrong on the first try and you have a lot more work to do.

My first question deals with whistleblowers. Of course, I have made the point that I would not be able to perform my constitutional oversight of the executive branch without Federal whistleblowers. They shed light on matters that affect public safety and the public purse, and oftentimes risk losing their jobs. They expose incompetence and promote reform that leads to better government. Their perspective has done a lot of good.

The FDA faces accusations that it monitored nine FDA scientists' personal e-mail accounts. However, the Health and Human Services Office of Inspector General concluded that the employees did not leak genuinely confidential classified information.

Instead, it looks like FDA monitored these accounts because whistleblowers were talking to the Office of Special Counsel, and in the case of Congress some of the e-mails of people on my staff came up, showed up. So I am very concerned about this. FDA's retaliation is shocking, it may be unlawful, and it should not be tolerated.

I am committed to getting to the bottom of it. That is why, today, Chairman Issa and I are sending a letter to the U.S. Office of Special Counsel to launch an investigation into the facts and circumstances surrounding e-mail monitoring. I would ask permission to put that letter in the record, Mr. Chairman.

Senator HATCH. Without objection.

[The letter appears in the appendix on p. 35.]

Senator GRASSLEY. So here is my question. Do you agree that searching through employees' personal e-mails is all right just because they contacted the Special Counsel or Congress, and would you agree that that would be unacceptable?

Secretary SEBELIUS. Senator, I certainly share your concerns about the potential retaliation against any whistleblower and feel that government employees need to have whistleblowers protections.

On the other hand, I think the FDA needs to have protections around proprietary information. As you know, this case is in litigation.

Senator GRASSLEY. We are talking about personal e-mails, though, here. Is it all right?

Secretary SEBELIUS. Senator—

Senator GRASSLEY. Go ahead.

Secretary SEBELIUS. It is my understanding, and I again cannot really discuss a lot with the litigation, but my understanding is there was some monitoring of office e-mails, and screen shots may have appeared that accessed a personal e-mail. There was no monitoring of personal e-mails that had anything to do with anything outside of the office space. That is something that Federal employees throughout government are put on notice about, that their e-mails can be monitored.

Senator GRASSLEY. Well, let me lead into this question then. Now, FDA may have the right to monitor e-mails sent from government computers. But if the evidence shows that the FDA captured e-mails that were not sent from a government computer, then do you agree that that would be inappropriate?

Secretary SEBELIUS. Again, Senator, this is in litigation, and I really do not want to speculate.

Senator GRASSLEY. All right.

Secretary SEBELIUS. I do know that employees are put on notice that their government e-mails will be monitored.

Senator GRASSLEY. Could I get this sort of a commitment from you: would you commit to ensuring that the FDA fully cooperates with the Special Counsel's investigation?

Secretary SEBELIUS. To the extent that they can while litigation is under way. I assume they will listen to the Justice Department about what they can and cannot do. But yes, sir. I think that everyone shares your concern about inappropriate and certainly any kind of retaliation against whistleblowers. I also think that you would share our concern that the release of proprietary information that may disadvantage companies, which is how this incident came to light, is also of concern.

Senator GRASSLEY. All right.

For years now I have been working on the Physicians Payment Sunshine Act which was included in the health reform bill 2 years ago. I want to emphasize, 2 years ago. I am disappointed that CMS is taking so long to issue the sunshine regulations. The proposed regulations were 2 months late.

Last week, the Office of Management and Budget said the law would not be fully implemented until—can you believe it?—December 2014. In the absence of final guidance, companies cannot prepare to comply with the law. CMS does not seem to be taking this seriously or working to implement the law with any sense of urgency.

Your agency has implemented many other provisions of the health care reform law already. Just think of all the ones you have already put out. The longer you delay the provision, the longer consumers will have to wait to learn about financial relationships between their doctors and drug and medical device companies. How can you wait until December 2014 to issue a final regulation when the law requires companies to begin reporting information in March 2013?

Secretary SEBELIUS. Senator, I just wanted to clarify. The final rule, as you know, has been finalized and is out and available. We are talking about a time table for reporting. This is a balancing act. I again share your concerns that consumers have the information about relationships that may influence their provider's decision.

A lot of health care providers are very concerned that additional reporting requirements may indeed impede their ability to practice medicine, so we are trying to have a balance between the public right to know and the provider's sensitivities.

Senator GRASSLEY. Let me correct you. The final rule cannot be out because the comment period ends Friday of this week, or Friday of next week.

Secretary SEBELIUS. I apologize, Senator. We are talking about—I am thinking of the rule that may apply to NIH scientists and reporters dealing with sunshine. But I will get you an updated time table. I apologize.

Senator GRASSLEY. All right. But we need to have the companies know what this is a long time before March of 2013.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. Madam Secretary, it is a pleasure to have you before our committee. I appreciate the way that you are moving forward to implement the Affordable Care Act.

You sometimes get inconsistent messages from my colleagues in Congress, but I can tell you—

Secretary SEBELIUS. Never. [Laughter.]

Senator CARDIN [continuing]. As I travel through Maryland, I run into people who are affected every day in a positive way by what we did. Seniors now see a light at the end of the tunnel on the coverage gap for their prescription drugs. There just was a family last night that dealt with keeping their children on their policies at age 26. I can tell you, we have opened and expanded clinics in Maryland that are now covering prenatal care and dental care where they did not have that coverage before the initiatives within the Affordable Care Act. So I want to start off by just saying "thank you."

I understand there is frustration that regulations and implementations are not moving as rapidly as some members would like to see. It would be nice if we gave you the budget supports you need, particularly at CMS, in order to be able to implement those programs. I am going to work with you to achieve that.

I want to at least concur in the comments of Senator Wyden on the shortage of drugs. That is unacceptable in America, that these drugs are not available. I certainly understand your need for notification, but there are manufacturers that are not being totally forthcoming on these issues, and we have to make sure that the supplies are available. I think we have a responsibility to act. I hope that we will find a way, consistent with the philosophy of our country, to make sure that those types of shortages do not exist in the United States.

I want to talk about the FDA budget. Of course, you mentioned the FDA. Their budget only gets a modest increase under the President's numbers. But more disturbing to me is the NIH budget. The

National Institutes of Health are frozen in the budget that you have submitted.

We rely on NIH to give us the answers to a lot of the medical mysteries that are out there and to provide the foundation for research that is important for innovation and job growth in America. I have been to NIH many times and have talked to the scientists who are working there, and I know the number of opportunities that are there that are not being moved forward because of the limited resources.

So I would have hoped that we would have seen from the administration a greater priority for the NIH budget, and I wanted to give you an opportunity to respond as to the priority that NIH is receiving under this administration.

Secretary SEBELIUS. Well, thank you, Senator. I do share your feeling that one of the most significant areas for not only the prosperity of our Nation, but really the world, is the ongoing biomedical research going on at the NIH. I am struck by, not only how important it is in this country, but around the world.

What I can tell you is that NIH, as one of our largest agency budgets, is always difficult to look at. While a number of our agencies have cuts in this year's budget, the NIH budget is, as you say, kind of held harmless. Having said that, Dr. Collins, I think, has done an extraordinary job adjusting resources so that we will continue the progress. This budget supports a 7.7-percent increase in new grants, so there will be 672 new research grants as part of this budget.

The Cures Acceleration Network and the Center for Translational Science, which are two high priorities of Dr. Collins, which help, again, accelerate not only strategies within government, but leverage our private partners toward cures and toward disease outcomes that are positive, have fairly significant increases in this budget. So, while it is a level funding, it is focusing resources on areas with the most promise.

Senator CARDIN. And I appreciate that. I look forward to working with you. I think that is a good point, that we need to set priorities within NIH. I agree with you. I want to make sure Senator Carper has an opportunity. I know we have a vote on.

But let me just raise the issue of post-acute care. You have a large cut in Medicare in your budget, I think some \$50 billion. Post-acute care has already sustained substantial reductions in recent efforts. I know that there is concern that we target fraud and abuse and waste. I would just urge us to be more surgical as we look for savings rather than using across-the-board issues that could jeopardize access to post-acute care.

Secretary SEBELIUS. We would love to work with you on that issue. Thank you, Senator.

Senator CARDIN. Thank you, Mr. Chairman.

Senator HATCH. Senator Carper?

Senator CARPER. Mr. Chairman? All right, Senator Hatch.

Senator HATCH. Just a humble servant here. [Laughter.]

Senator CARPER. Madam Secretary, welcome. I just want to thank you for a couple of things. One, Accountable Care Organizations. We all know that we have to move away from fee-for-service to a more coordinated care approach. They will put out some draft

regulations on Accountable Care Organizations. We heard that from a lot of people, and you did as well.

I just want to commend you and your team for responding to those comments and helping to create an environment where we are going to see a lot of these Accountable Care Organizations established, including, I hope, in Delaware.

We had Jonathan Blum who was up and met with our bunch of hospital and provider folks a week or two ago. He did a very nice job. And we are encouraged and excited about that. As you know, one of the things we focus on, as you do, is how to get better results for less money or better results for the same amount of money.

As we try to figure out how to save money everywhere in government, to the extent that we can find ineffective, inefficient spending, whether it is these improper payments or just fraud, we want to go after that. I am told that you all may have announced, even yesterday I think you may have announced, a record level of health care recoveries totaling over \$4 billion for 2011. That is up from almost nothing just a few years ago. So, thank you so much to everybody who is working hard to make that happen.

I worked, along with some of my colleagues, Senator Harkin and Senator Murkowski, on menu labeling to make sure that, when people go into a chain restaurant across this country, they will actually know, not just the item being served and the price, but they will actually know calories and a lot of other information about the items being served. I understand that you all are pretty well along the way in terms of us being able to have that information going in to restaurants. So, we thank you for that too.

I do have a question in all this. My question is, can you just take a moment and explain how some of the additional \$1 billion in funding that the President requested for CMS will be allocated within the agency to support innovative initiatives, such as ACOs? For example, will the CMS Innovation Center receive any additional support to expand upon the ACO model and other health delivery system reforms? Is that a fair question?

Secretary SEBELIUS. It is certainly a fair question. But let me answer it kind of in two parts. The Innovation Center initiatives are really a separate line of funding. As I explained to an earlier question, we see it as our kind of R&D operation around health care innovation throughout the country. We have had enormously enthusiastic response from providers, from private payers, from insurers. We have a number of programs under way, and we are going to continue to find new ways to support that.

The billion-dollar request in the administrative side of the CMS budget has about \$800 million dedicated to setting up the infrastructure for the Federal exchange program. A lot of it is 1-time costs for outreach efforts and IT efforts and the build that will be required to have that up and running. About \$200 billion is dedicated to ongoing enhancements of Medicare and Medicaid service operations. Both programs, as you know, have increasing enrollment, and we want to make sure that we continue to fund them.

With that said, Senator, because I know this is a concern of yours just in terms of overhead costs, I can report to you that, if this request is fully funded, the CMS administrative costs will still be less than 3 percent, even with the billion-dollar increase of our

overall program expenditure. I think that compares favorably with any private sector overhead costs for a major insurance company.

Senator CARPER. All right. Good. Thanks.

The other thing I wanted to mention, just very briefly, is, we had a hearing in the subcommittee I chair on Federal financial management, and we looked into the use of the prescribing of these so-called psychotropic drugs, mind-altering drugs, for children. We looked especially at foster care children who are in the Medicaid program.

Secretary SEBELIUS. Yes.

Senator CARPER. And we found that there were kids under the age of 1 who were receiving more than one of these psychotropic drugs. We had a little boy who was like 12 who was one of our witnesses, and he had been taking five or six of these drugs. They made sort of like a cocktail for him, and it was just really screwing up his life.

What he really needed was for somebody to love him and to take him into their home and just make sure he had nurture and care, and he finally got that and he does not take any kind of medicine now. But this is something that is of great interest to us. We started looking at it, the idea of better results for less money. Are we wasting money in Medicaid? What we found out is just, we are not using best practices.

I just want to put that out. You have a lot of things to say grace over, but that is something we are working on, and your folks are working on it as well, and basically reaching out to the States and saying, all right, let us see if we cannot figure out what is working in some of the States to deal with kids with these problems and what is not.

Senator HATCH. Senator, I have to get to a vote, so I need to gavel this down. See how easy this has been for you today? I think we should do this once every month. [Laughter.]

Secretary SEBELIUS. Really? [Laughter.]

Senator HATCH. Really. You run such a huge agency. The one thing I would like to just say is, if you could, we have given copies of our letter, and your letter which we felt was unresponsive. If you could answer that by the end of this month, we would be very appreciative. Have your folks answer that and be responsive. I would really appreciate it.

With that, is it all right if I gavel—

Senator CARPER. Madam Secretary, I am just going to ask, I will submit a follow-up question in writing on the issue of the foster children and psychotropic drugs.

Secretary SEBELIUS. Absolutely. It is something we would love. Commissioner Samuels and our Assistant Secretary are very eager to continue pursuing this issue.

Senator CARPER. Thank you.

Thanks, Mr. Chairman.

Senator HATCH. Thank you, Madam Secretary.

Secretary SEBELIUS. Thank you.

Senator HATCH. Thank you for being here.

Secretary SEBELIUS. Thank you, Senator Hatch.

Senator HATCH. With that, we will recess until further notice.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

**Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Our Health and Human Services Programs and the President's Budget Proposal**
As prepared for delivery

President Dwight Eisenhower once said, "Unless we progress, we regress."

Since passing the Affordable Care Act, we've made tremendous progress on the health care front. Health reform is saving millions of Americans money, giving them more choices and better access to their doctors.

Prescription drugs are cheaper for seniors. In fact, 3.6 million Medicare beneficiaries saved more than two billion dollars last year. That's because health reform closes the prescription drug donut hole. To date, 2.5 million young adults, many facing a difficult job market, have been able to stay on their parents' coverage. And 40,000 Americans who were denied insurance due to a pre-existing health condition have been able to obtain coverage through state-based high-risk pools.

Vera Uzelac from Billings, Montana can sure tell you how health reform has helped her. Like most seniors, Vera lives on a fixed income and has to be conscious of every penny she spends to get by. Before health reform, Vera was forced to pay as much as \$85 a month for one prescription. But now Vera is saving at least \$20 every month on the medicines she needs, which frees up money for groceries and other necessities.

Or take Sheila Lopach from Helena, Montana, whose 24 year-old daughter is in school and had no health coverage. Thanks to health reform, young adults across the country like Sheila's daughter can stay on their parents' insurance coverage, and parents like Sheila can worry a little less.

Just as health reform reduced costs for individuals and businesses, the law reduced government costs, most notably through Medicare. The health reform law also provided the biggest deficit reduction in more than a decade. According to our nonpartisan scorekeeper, the Congressional Budget Office, the law will reduce deficits by \$143 billion dollars in its first ten years and by more than \$1 trillion in the decade that follows.

We need to continue this progress. We look forward to hearing from Health and Human Services Secretary Kathleen Sebelius today about how the President's budget will do that.

Today, nearly 48 million Americans are enrolled in Medicare. As the baby boom generation retires, the number of seniors eligible for Medicare will increase rapidly. Over the next decade, 18 million additional Americans will enroll in Medicare. We need to ensure these beneficiaries – and future generations – receive the benefits Medicare guarantees. To strengthen Medicare, we need to continue lowering costs. We need to spend our

precious health care dollars wisely and efficiently. If we do, we will lower premiums for seniors enrolled in Medicare today and keep the program strong for the generations to come.

This is the path health care reform took, and we're already seeing the results. Two weeks ago, CBO released a report showing that over the next ten years, costs per-beneficiary will average "just one percent a year more than the rate of inflation." This is significantly better than the last twenty years. From 1985 to 2007, these costs grew five percent faster than inflation. This is major progress, though we can do even more. If per capita health care costs were to slow by one percentage point over ten years, the federal government would save \$800 billion.

Secretary Sebelius, we provided you with the tools in the Affordable Care Act to continue to lower costs and bend the cost curve. When doctors and hospitals don't talk to each other, patients receive the same tests twice. That's why health reform improves communication and coordination among providers. Expensive diseases can be better managed if they are caught early, so health reform provides free preventive care. And criminals try to rip off taxpayers, so health reform provides law enforcement new tools and resources to protect Medicare and Medicaid from fraud. I'm pleased to hear that the administration's anti-fraud efforts have recovered more than \$4 billion just last year.

We know that some of the best ideas won't come out of Washington, but from our own communities. That's why health reform created the Medicare and Medicaid Innovation Center to leverage these good ideas and partner with the private sector. Secretary Sebelius, I'm pleased to see that you're enlisting private sector partners. The recent Innovation Challenge has sparked thousands of ideas from the best providers our system has to offer, including some from my own state of Montana.

Never before has the need to rein in out of control health care costs been higher. Never before has the consensus for action been stronger. Madame Secretary, I urge you to continue to use the tools provided by health reform.

The goals and responsibilities of your Department are broader than health care. Our nation must revisit the ways we prevent poverty. Our economy has continued to recover, and I'm pleased to see that the budget reflects that positive growth. However, our work is far from complete. The human service programs we will work on this year present significant opportunities to build upon the strengths of the American family. We must find the best and most effective ways to help families in economic crisis. Temporary Assistance for Needy Families must be maintained for the well-being of children and families facing dire circumstances.

I was pleased to work with Senator Hatch and the many child welfare champions on this Committee to reauthorize the Safe and Stable Families Program last year. We should consider the lessons we learned and the principles that guided us during that process as we work to reform the entire child welfare system.

So let us improve these human service programs. Let us work together to strengthen Medicare and Medicaid. Let us make our health care system more efficient. Let us build on the health reform law. Let us heed President Eisenhower's warning that unless we progress, we regress.

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SUBMITTED BY SENATOR COBURN

January 18, 2012

The Honorable Barack Obama
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

On behalf of 19 state hospital associations and the millions of Medicare beneficiaries our members annually care for, we respectfully ask that you include language in your FY 2013 Budget Submission to Congress that addresses the adverse impact of Sec. 3141 of the Patient Protection & Affordable Care Act (PPACA). As reported in several news stories, this PPACA provision permitted the Commonwealth of Massachusetts to manipulate the federal Medicare program, reaping an estimated \$367 million annually from the other 49 states – and unfairly favoring one state’s hospitals and Medicare beneficiaries to the detriment of others.

If left uncorrected, hospitals in 49 states will experience reduced funding of more than \$3.5 billion over the next ten years as a direct result of this manipulation of Medicare’s hospital wage index. Hospitals nationwide are already struggling with reduced government payments and the potential for cuts through the federal deficit reduction discussions and health care reform. Scarce Medicare funding should reward value and efficiency in health care, not be diverted based on artful manipulation of obscure payment formulas.

Recently, your leadership at the Centers for Medicare & Medicaid Services (CMS) expressed its concerns that changing hospital status, such as what was done in Massachusetts (via PPACA), results in significantly inflated wage indexes across a state "...in a manner that was not intended by Congress..." CMS further



calls this a "...manipulation..." and hints that if this action is not stopped, there is the potential for more states to further redistribute hospital payments based not on patient or community need, but on a manipulation of the Medicare program.

Similarly, the Medicare Payment Advisory Commission (MedPAC) noted that this "...exception triggered in the state of Massachusetts will have a large impact on hospital payments..." MedPAC further stated that as a result of the budget neutral change, "...all hospitals – including rural hospitals – will absorb the financial loss..."

We all understand and appreciate the challenging financial environment that our nation confronts, but unless this problem is swiftly corrected, it could serve to impede your administration's goals of moving toward value-based purchasing and accountable care. Therefore, we respectfully ask that you help us right this wrong and address this ill-advised provision. We look forward to working with you on this matter.

Sincerely,

Michael Hanley

Ben Lyall

Walter Gatti

Jeff Pahr

Keith Norriss

Michael T. Root

John Matessano

Bob Roth

John W. Lannon

David Holmberg

Luca Finley

Mary L. Gallagher

David D. Jones

William S. Davidson

John P.

Rose Hewitt

Christina Santoro

Joseph M. Jaramila

Steve Puzos

SUBMITTED BY SENATOR GRASSLEY

Congress of the United States
Washington, DC 20515

February 15, 2012

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

Dear Ms. Lerner:

We are writing to request that the U.S. Office of Special Counsel (OSC) investigate whether the Food and Drug Administration (FDA) violated the Whistleblower Protection Act (WPA) or the Stored Communications Act (SCA) by covertly monitoring employees who communicated confidentially with Congress about a potential danger to public health. A lawsuit filed in U.S. District Court in Washington, D.C., alleges that the FDA relied on information it collected through secret surveillance to “fire, harass or pass over for promotion at least six doctors and scientists who communicated with Congress.”¹ The employees under surveillance were also communicating with OSC.

The WPA expressly provides that the statute is “not to be construed to authorize . . . the taking of any personnel action against an employee who discloses information to the Congress.”² Denying or interfering with employees’ rights to furnish information to Congress and the OSC is against the law and will not be tolerated at any federal agency.

The *Washington Post* reported that the FDA monitored the personal e-mail accounts of a group of nine agency scientists (“the FDA nine”) after learning they shared concerns about the medical device review process with Congress, and specifically, with our offices. Among the scientists whose e-mail was subject to monitoring was Paul Hardy. The FDA used information collected from Hardy’s personal e-mail account to build the case for firing him. In November 2011, OSC filed a request for a retroactive stay of Hardy’s marginal performance evaluation—which was used in part to justify his removal—because “it had reasonable grounds to believe that Hardy’s performance evaluation was based on reprisal for protected disclosures he had made.”³

In a May 5, 2011, memo entitled “Misconduct of LTJG Paul. T. Hardy,” sent from the FDA to Gregory Stevens, the Acting Director of the Office of Commissioned Corps Operations in the Office of the Surgeon General, the agency included several exhibits to “back-up”

¹ Ellen Nakashima and Lisa Rein, *FDA says it monitored workers' e-mail to investigate potential leak*, WASH. POST, Feb. 9, 2012. [hereinafter Nakashima and Rein]

² Congressional Research Service Report RL33918.

³ U.S. Merit Systems Protection Board, Docket Nos. CB-1208-12-0002-U-2 and CB-1208-12-0002-U-3, Nov. 23, 2011.

The Honorable Carolyn Lerner
 February 15, 2012
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assertions of the agency's "lack of trust" in Hardy, including a January 29, 2009, e-mail from Hardy to the House Committee on Energy and Commerce. In a February 9, 2012, *Washington Post* article, however, FDA spokesperson Erica Jefferson stated, "In fact, our targeted monitoring of e-mail content of these individuals was not initiated until April 2010, when it was brought to our attention by a company that confidential and proprietary information had been leaked to the public."⁴

The fact that the FDA is in possession of an e-mail from Hardy's personal account to Congress from January 2009—more than one year prior to the date on which FDA admits commencing surveillance—suggests that the FDA may have accessed Hardy's personal e-mail to retrieve prior communications that were not necessarily sent from a government computer. This could also be the case for the rest of the FDA nine, and it raises questions about the legality of the monitoring under the SCA. While monitoring activity on a government computer may be justified in certain circumstances, absent a subpoena it is difficult to imagine a justification for obtaining access to an employee's personal e-mail account for the purpose of mining for messages that were not transmitted through a government computer.

Perhaps more troubling, however, is that the surveillance was not limited to the FDA nine's communications with Congress. FDA's surveillance also intercepted protected communications with OSC. A February 1, 2012, story in the *Washington Post* states:

Documents show FDA officials thought the reviewers disclosed confidential information when they communicated concerns to congressional staffers, the White House, the Equal Employment Opportunity Commission and the special counsel's office.⁵

Because OSC is bound by law to maintain the confidentiality of information it receives, there could have been no legitimate reason for FDA to monitor or intercept communications with OSC.⁶ In fact, OSC is specifically authorized to receive both national security information and information that would otherwise be "specifically prohibited by law" from disclosure.⁷ Additionally, the WPA prohibits agencies from taking adverse personnel actions against individuals who make protected disclosures to OSC.⁸

In order to better understand the actions taken by the FDA with respect to the FDA nine, we respectfully request that OSC initiate an investigation into the facts and circumstances surrounding the e-mail monitoring. Specifically, we request that OSC examine (1) whether the monitoring occurred in retaliation for protected whistleblowing activities and thus may constitute a prohibited personnel practice, and (2) whether the monitoring may have violated any other law,

⁴ Nakashima and Rein, Feb. 9, 2012 (emphasis added).

⁵ Ellen Nakashima and Lisa Rein, *Grassley opens investigation into FDA surveillance*, WASH. POST, Feb. 1, 2012 (emphasis added).

⁶ See, e.g., 5 U.S.C. §§ 1212(g)(1), § 1213(h).

⁷ For example, even trade secret information may be legally disclosed to the OSC. U.S. Merit Systems Protection Board, Docket No. DC07529010241, Mar. 8, 1993.

⁸ 5 U.S.C. § 2302(b)(8).

The Honorable Carolyn Lerner
February 15, 2012
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including the Stored Communications Act (18 U.S.C. §§ 2701 - 2712) as an unauthorized access of stored electronic communications or as a failure to provide notice to the subscriber of court-approved access.

Thank you for your attention to this matter. Please contact Erika Smith of the Senate Committee on the Judiciary at (202) 224-5225 or Jonathan Skladany of the House Committee on Oversight and Government Reform at (202) 225-5074 with any questions about this request.

Sincerely,



Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate



Darrell Issa
Chairman
Committee on Oversight
and Government Reform
United States House of Representatives

cc: The Honorable Patrick Leahy, Chairman
Committee on the Judiciary
United States Senate

The Honorable Elijah E. Cummings, Ranking Member
Committee on Oversight and Government Reform
United States House of Representatives

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF FEBRUARY 15, 2012
PRESIDENT'S FISCAL YEAR 2013 HEALTH CARE PROPOSALS**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Committee on Finance, delivered opening remarks at a committee hearing examining the President's Fiscal Year 2013 budget proposal with Health and Human Services Secretary Kathleen Sebelius.

A full copy of Hatch's remarks, as prepared for delivery, follows:

Mr. Chairman, thank you for scheduling this hearing today. And Secretary Sebelius, thank you for taking the time to come here to speak with us. We have a lot to talk about. Since it has been over 300 days since you have testified before this committee, which oversees much of your budget, I suspect it comes as no surprise that our list of questions is long.

The question that American taxpayers are asking is how the President proposes to balance the budget and how he intends to get our nation's debt and entitlement spending under control.

After all, he promised when he was elected that he would cut the deficit in half by the end of his first term.

Yet with a fourth straight trillion dollar deficit under the nation's belt, the expiration date on that election-year promise is long past.

I think many Americans would be willing to cut the President some slack, if he demonstrated any willingness to lead us out of our debt crisis.

But with this budget, he again demonstrates that he would rather pursue his own political gain over fiscal stability.

The budget completely fails to address the gathering storm of our entitlement crisis. But don't take my word for it. Just look at what everyone from the *Washington Post* to the *Wall Street Journal* are saying about this budget.

According to the *Washington Post* the budget, *begins with a broken promise...omits all kinds of painful decisions.*

The assessment of *Businessweek* is equally grim. The budget *does little to restrain growth in government's huge health benefit programs.*

And the *Wall Street Journal* hits it on the head, concluding that it is *a brilliant bit of misdirection...voters need to suspend disbelief for another nine months.*

At the same time that the President cuts the defense budget and complains about the lack of spending on infrastructure, his budget ignores that entitlement spending is crowding out these priorities.

Medicare, Medicaid and Social Security will increase as a percentage of GDP from 9.7 percent to 11.2 percent over the next 10 years. Federal Medicaid spending as a percentage of GDP will increase from 1.6 percent to 2.1 percent over the next decade — an astonishing 30 percent increase in the federal portion of the program.

Mandatory health spending under the President's budget actually increases by \$72 billion, since the modest \$366 billion in savings over 10 years are wiped away by an undefined \$438 billion proposal to fix the physician payment formula.

I wish I could say that this budget contained smoke and mirrors.

But it doesn't. It is, rather, a transparent abdication of any responsibility to fix the entitlement spending crisis.

Medicare remains on a path toward bankruptcy, and with it, senior impoverishment. Under the President's baseline estimates, Medicare and Medicaid are projected to spend \$11.1 trillion over the next 10 years.

This level of spending is simply not sustainable. According to the 2011 Medicare Trustees Report, the Hospital Insurance Trust Fund has \$8.3 trillion in unfunded liabilities and is expected to be insolvent by 2024.

Real choices — difficult choices — are necessary. But the President refused to make them in his health law, and he refuses to make them now. Astonishingly, the President's comprehensive health law failed to address the Sustainable Growth Rate formula which is used to determine payments for physicians, despite cutting \$529 billion from the Medicare program.

With respect to Medicaid, the budget baseline proposes spending \$4.37 trillion on the program over the next 10 years. This amount includes the health law's new spending on the largest expansion of the Medicaid program since it was created in 1965. Furthermore, the budget fails to respond to repeated requests from governors for any real flexibility to implement solutions that work for their citizens.

And for the third year in a row, the President's budget proposes increased spending while failing to propose a financially responsible long-term authorization of the Temporary Assistance for Needy Families program which will expire at the end of this month.

In his health law, the President famously promised to bend the cost curve with respect to health expenditures. He failed to do so with that law, and with this budget he has failed again. Over the next 10 years, total mandatory spending for Medicare and Medicaid will exceed \$11 trillion.

The President's budget would only reduce that amount by \$366 billion, a trifling reduction of 3.6 percent over the next decade.

Over the 75 year window, it translates into a rounding error — a reduction of one-half of one percent.

As insignificant as these spending reductions are, it has become clear that the President is not serious about achieving even them. He has suggested that unless Congress adopts his tax schemes for wealth redistribution, any adjustments to entitlement spending is off limits.

The President's reelection advisors in Chicago might think that it is politically advantageous to hold entitlement reform hostage to his class warfare proposals, but it is fiscally irresponsible.

Thank you again Mr. Chairman. And Secretary Sebelius, I look forward to a fruitful dialogue.

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**Senator Jay Rockefeller Statement for the Record
Senate Finance Committee Hearing on
“The President’s FY2013 Budget Proposals”
February 15, 2012**

Madame Secretary, thank you for appearing before the Finance Committee for this budget hearing. It comes at an important moment in our long journey towards a better, more affordable health care system, and at a critical juncture in our economic recovery. It gives us all a chance to reflect on the role that each of us can play in promoting an important American value: opportunity for all. The Department we are here to discuss today – Health and Human Services – can help us reach that shared goal.

As many of us here would agree, a good health care system is essential to helping all Americans reach their full potential and contribute their hard work, creativity, and energy to America’s economic engine. Because of enactment of the Affordable Care Act, the first comprehensive health care plan our country has ever had, we are already entering a transformational time of improving health for our citizens. In this 21st century era of global competition for jobs and opportunity, good health and access to safe, affordable health care is absolutely critical for our success as a nation. I am happy to welcome you today to hear how we are achieving this.

Not quite two years ago, Congress passed the Affordable Care Act, and it took us the better part of a generation to get there. Never before have we had so much opportunity to make life better for my home state of West Virginia and for all states across the country, or so much responsibility to do so. It is a pleasure today to begin by recognizing some of the many early success stories we are hearing as a result of those efforts.

Health reform is already bringing more opportunity to millions of Americans. To name one example, just last week, your Department announced the Strong Start Initiative to help reduce preterm births and improve the health of babies in America. This new program will help make sure that every baby has a chance at a healthy start by looking at the disturbing trend of premature births in this country, a number that has grown by 36 percent over 20 years. In West Virginia alone, 2,739 babies were born preterm in 2009, nearly 13 percent of all newborns. These infants often require additional medical attention and early intervention services, and may have special education needs lasting into adulthood. Families suffer emotional and financial strain. Strong Start is just the type of public and private partnership we need to continue to build better, safer, more affordable health care for all Americans.

Here are just a few of the other opportunities created by the health reform law:

- 2.5 million young adults have gained health insurance coverage by being allowed to stay on their parents’ insurance plans until age 26. Previously one of the largest segments of the uninsured, nearly 7,000 young West Virginians now have this option.
- Seniors across the nation are now able to get free preventive services such as high blood pressure screening, mammograms, and an annual wellness visit with no copays, coinsurance, or deductible costs. Just in West Virginia, 372,000 people have access to

these vital preventive services. For these seniors, the days of waiting for pain or life threatening symptoms to occur before seeking a doctor's care are past.

- Prescription drugs are more affordable for thousands of seniors. By 2020, the new law will fulfill its promise of closing the Medicare "doughnut hole" completely. In 2011, 36,036 West Virginia seniors saved over \$23.5 million because of discounts on prescription drugs in the doughnut hole -- an average of \$650 per beneficiary.
- Consumers now have new protections when purchasing health insurance. More than 40,000 Americans living with pre-existing medical conditions that made them uninsurable now have affordable coverage under the Pre-Existing Condition Insurance Plan. Discrimination is prohibited against children with pre-existing conditions. The Patient's Bill of Rights holds insurance companies accountable and prevents arbitrary annual or lifetime dollar limits on benefits affecting 907,000 West Virginians and millions nationwide. And, insurance companies will finally have to provide clear summaries of the benefits they cover, instead of hiding behind loopholes that cost patients dearly.
- Renewed efforts by the Department of Health and Human Services and the Department of Justice have resulted in halting nearly \$3 billion dollars worth of fraudulent claims in 2011 alone. Public funds must be spent wisely and we must be certain that our health care dollars are spent for the purposes they are intended. Stopping fraud makes sure resources are directed toward strengthening programs such as Medicare and Medicaid.

I believe these early indicators bring good news of the shift in the health and well being of the country. For a program that is not yet two years old, the returns have been meaningful, particularly in the lives of our most vulnerable citizens: our seniors and our children.

Of course, there will continue to be naysayers, those who would seek to roll back the progress that has been made in health care for America. But in seeking to repeal the law, not a single workable proposal has been put forward to replace it. The health care reform law is creating real, meaningful, life-changing, and in some cases, life-saving new laws and policies for West Virginians and for all Americans. We cannot quit. We owe it to our children and to our seniors and to the workers of this country to move forward.

Today, I am eager to learn details of how the President's FY2013 budget will help keep us moving forward with positive changes to transform the health of this nation. Already there are successes in consumer protections, support for our seniors, lowering costs, and reducing quality. I also understand the vital importance of containing health spending -- but want to make sure we are doing so in a way that does not arbitrarily shift costs to seniors and low-income Americans.

I am especially concerned that we continue to move forward, not backward, when it comes to the Medicaid program. Besides covering children, Medicaid is the program that working families, seniors, and persons with disabilities rely on for their health care. It is the program that many turn to when times are hard; and in the recent recession, Medicaid and CHIP actually helped to increase coverage for children. The uninsured rate for children actually dropped to 8% in 2010, the lowest point ever achieved since the federal government began tracking this statistic in 1987.

And 16 million Americans will gain coverage under Medicaid thanks to health reform – coverage they would not be able to find anywhere else.

Medicaid creates huge economic benefits in communities across the nation, and health care jobs in general are the fastest growing job sector in the country. Twenty percent of rural doctor fees come from Medicaid, and may make all the difference in that doctor choosing to stay in rural practice. There are nearly 400,000 people in West Virginia who get health care through Medicaid, and 19,800 nurses, doctors, hospital workers, and community health center staff members have jobs because of Medicaid.

Just last summer, researchers from Harvard and MIT announced the results of a groundbreaking study, showing that the Medicaid program works to improve health and keep families out of financial crisis due to a health problem. We must build on that success. This is why I am concerned about some of the policies in the budget that would shift Medicaid costs to states and beneficiaries – even as I applaud the budget for guarding against catastrophic policies like Medicaid block grants. But going backward is not a choice, and I look forward to working with the Administration to strengthen Medicaid.

One of the key areas in which we simply must strengthen Medicaid is in the area of long-term services and supports. Medicaid is the primary payer for these services nationwide, and long term care comprises about one-third of total Medicaid spending. With nursing home costs averaging about \$75,000 per year, it does not take long for middle class seniors to spend-down their life savings so they can enroll in Medicaid. Many states are trying to improve long-term services and supports: thirty-two states in FY 2011 and 33 states in FY 2012 took actions that expanded these services, primarily expanding home and community-based service programs that help seniors and people with disabilities live more independently at home. But in some states the opposite was true: a total of 14 states in FY 2011 and 11 states in FY 2012 took action to restrict these services. Health reform included a number of new options designed to help states increase community based long-term services and supports. I am encouraged that many states are moving forward with home and community based services, just as I am encouraged that the new Medicare-Medicaid Coordination Office is now working to improve the quality of care for dually eligible beneficiaries. We must press forward with these reforms, and ultimately, we must at last find a solution to the long-term care crisis that will only continue to grow as our population ages.

I also want to mention the human service side of your agency. I am pleased that your Department is proposing new investments in child welfare because these children are among our most vulnerable. It is also good to note that in recent years, there has been bipartisan legislative action and good news in reducing the number of children in care and the length of their time in foster care. It is also a point of pride that the number of children adopted from foster care has improved.

The President's commitment to fatherhood and child support is well known and appreciated, but I am not sure that everyone realizes that 17 million children get over \$23 billion thanks to this efficient federal program. At a time of tight budgets, we should not cut such an effective program that on average returns \$4.70 for every \$1 dollar invested. I hope HHS and OMB are

also carefully reviewing the legal opinions that suggest child support enforcement should be exempt from the sequester, if that happens in January 2013.

I appreciate the stress on developing a budget, but the funding request for Low-Income Home Energy Assistance Program (LIHEAP) of \$2.57 billion is not acceptable. Last month, I cosigned, along with 39 Senate bipartisan colleagues, a letter seeking \$4.7 billion for the program. In such a downturn, it is harsh to suggest such a cut. I know that there must be a serious debate about this issue and I look forward to working with the Administration as we move forward.

Once again, Madame Secretary, thank you for the hard work that you and your Department do on behalf of all Americans. We can and must continue our forward progress to create better opportunities and a brighter future for our country.



**STATEMENT OF
KATHLEEN SEBELIUS
SECRETARY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

ON

THE PRESIDENT'S FISCAL YEAR 2013 BUDGET

**BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
FEBRUARY 15, 2012**

**Testimony of
Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
before the
United States Senate
Committee on Finance
February 15, 2012**

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to discuss the President's FY 2013 Budget for the Department of Health and Human Services (HHS).

The Budget for the Department of Health and Human Services (HHS) invests in health care, disease prevention, social services, and scientific research. HHS makes investments where they will have the greatest impact, build on the efforts of our partners, and lead to meaningful gains in health and opportunity for the American people.

The President's fiscal year (FY) 2013 Budget for HHS includes a reduction in discretionary funding for ongoing activities, and legislative proposals that would save an estimated \$350.2 billion over ten years. The Budget totals \$940.9 billion in outlays and proposes \$76.7 billion in discretionary budget authority. This funding will enable HHS to: Strengthen Health Care; Support American Families; Advance Scientific Knowledge and Innovation; Strengthen the Nation's Health and Human Service Infrastructure and Workforce; Increase Efficiency, Transparency, and Accountability of HHS Programs; and Complete the Implementation of the Recovery Act.

STRENGTHEN HEALTH CARE

Delivering benefits of the Affordable Care Act to the American People: The Affordable Care Act expands access to affordable health coverage to millions of Americans, increases consumer protections to ensure individuals have coverage when they need it most, and slows increases in health costs. Effective implementation of the Affordable Care Act is central to the improved fiscal outlook and well-being of the Nation. The Centers for Medicare & Medicaid Services (CMS) is requesting an additional \$1 billion in discretionary funding and 136 full-time equivalents to continue implementing the Affordable Care Act, including Affordable Insurance Exchanges, and to help keep up with the growth in the Medicare population.

Expand and Improve Health Insurance Coverage: Beginning in 2014, Affordable Insurance Exchanges will provide improved access to insurance coverage for more than 20 million Americans. Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop-shopping where they can compare benefit plans. New premium tax credits and reductions in cost-sharing will help ensure that eligible individuals can afford to pay for the cost of private coverage through Exchanges. FY 2013 will be a critical year for building the infrastructure and initiating the many business operations critical to enabling Exchanges to begin operation on January 1, 2014. The expansion of health insurance coverage for millions of low-income individuals who were previously not eligible for coverage also begins in 2014. CMS has worked closely with states to ensure they are prepared to meet the 2014 deadline and will continue this outreach in FY 2013.

Many important private market reforms have already gone into effect, providing new rights and benefits to consumers to put them in charge of their own health care. The Affordable Care Act's Patient's Bill of Rights allows young adults to stay on their parents' plans until age 26 and ensures that consumers receive the care they need when they get sick and need it most by prohibiting rescissions and lifetime dollar limits on coverage for care. The new market reforms also guarantee independent reviews of coverage disputes.

Temporary programs like the Early Retiree Reinsurance Plan ERRP and the Pre-Existing Condition Insurance Plan (PCIP) are supporting affordable coverage for individuals who often face difficulties obtaining private insurance in the current marketplace. Additionally, rate review and medical loss ratio (MLR) provisions help ensure that health care premiums are kept reasonable and affordable year after year. The already operational rate review provision gives states additional resources to determine if a proposed health care premium increase is unreasonable and, in many cases, help enable state authorities to deny an unreasonable rate increase. HHS reviews large proposed increases in states that do not have effective rate review programs. The MLR provisions guarantee that, starting in 2011, insurance companies use at least 80 percent or 85 percent of premium revenue, depending on the market, to provide or improve health care for their customers or give them a rebate.

Strengthen the Delivery System: The Affordable Care Act established a Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center is tasked with developing, testing, and—for those that prove successful—expanding innovative payment and delivery system models to improve quality of care and reduce costs in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The Innovation Center began operations in November 2010 and has undertaken an ambitious agenda encompassing patient safety, coordination of care among multiple providers, and enhanced primary care. These projects can serve as crucial stepping stones towards a higher-quality, more efficient health care system.

HHS is also working to ensure that the most vulnerable in our Nation have full access to seamless, high-quality health care. The Affordable Care Act established a new office to more effectively integrate benefits and improve coordination between states and the Federal Government for those who are eligible for both Medicare and Medicaid. While Medicare-Medicaid beneficiaries make up a relatively small portion of enrollment in the two programs, they represent a significant portion of expenditures. HHS is currently supporting 15 states as they design models of care that better integrate Medicare and Medicaid services and is designing additional demonstrations to continue to improve care.

CMS is currently offering three initiatives that will help spur the development of Accountable Care Organizations (ACOs) for Medicare beneficiaries. ACOs are groups of health providers who join together to give high-quality, coordinated care to the patients they serve. If an ACO meets quality standards, it will be eligible to share in savings it achieves for the Medicare program, and may be subject to losses, offering a powerful incentive to restructure care to better serve patients.

Ensuring Access to Quality Care for Vulnerable Populations: Health Centers are a key component of the Nation’s health care safety net. The President’s Budget includes a total of \$3 billion, including an increase of \$300 million from mandatory funds under the Affordable Care Act, to the Health Centers program. This investment will provide Americans in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services. This funding will create 25 new health center sites in areas of the country where they do not currently exist and provide access to quality care for 21 million people, an increase of 300,000 additional patients over FY 2012. The Budget also promotes a policy of steady and sustainable health center growth by distributing Affordable Care Act resources over the long-term. This policy safeguards resources for new and existing health centers to continue services and ensures a smooth transition as health centers increase their capacity to provide care as access to insurance coverage expands.

Improving Healthcare Quality and Patient Safety: The Affordable Care Act directed HHS to develop a national strategy to improve health care services delivery, patient health outcomes, and population health. In FY 2011, HHS released the National Strategy for Quality Improvement in Health Care, which highlights three broad aims: Better Care, Healthy People and Communities, and Affordable Care. Since publishing the Strategy, HHS has focused on gathering additional input from private partners and aligning

new and existing HHS activities with the Strategy. HHS will enhance the Strategy by incorporating input from stakeholders and developing metrics to measure progress toward achieving the Strategy's aims and priorities. Already, the Strategy is serving as a blueprint for quality improvement activities across the country.

CMS will continue funding for the Partnership for Patients, an initiative launched in April 2011 that sets aggressive targets for improving the quality of healthcare: reducing preventable hospital-acquired conditions by 40 percent and preventable readmissions by 20 percent by the end of 2013, as compared to 2010.

Investing in Innovation: HHS is committed to advancing the use of health information technology (health IT). The Budget includes \$66 million, an increase of \$5 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate the adoption of health IT and promote electronic health records (EHRs) as tools to improve both the health of individuals and the health care system as a whole. The increase will allow ONC to provide more assistance to health care providers as they become meaningful users of health IT. Furthermore, through the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act, CMS is providing hospitals and medical professionals who participate in Medicare and Medicaid with substantial incentive payments for the adoption and meaningful use of EHRs. As of the end of 2011, CMS had made incentive payments to 15,859 providers who have met the objectives for meaningful use in the Medicare EHR Incentive Program and 15,132 providers who have adopted, implemented, or upgraded EHRs in the Medicaid EHR Incentive Program. By encouraging providers to modernize their systems, this investment will improve the quality of care and protect patient safety.

SUPPORT AMERICAN FAMILIES

Healthy Development of Children and Families: HHS oversees many programs that support children and families, including Head Start, Child Care, Child Support, and Temporary Assistance for Needy Families (TANF). The FY 2013 Budget request invests in early education, recognizing the role high-quality early education programs can play in preparing children for school success. The request also supports TANF and proposes to restore funding for the Supplemental Grants without increasing overall TANF funding.

Investing in Education by Supporting an Early Learning Reform Agenda: The FY 2013 Budget supports critical reforms in Head Start and a Child Care quality initiative that, when taken together with the Race to the Top Early Learning Challenge, are key elements of the Administration's broader education reform agenda designed to improve our Nation's competitiveness by helping every child enter school ready for success.

On November 8, 2011 the President announced important new steps to improve the quality of services and accountability at Head Start centers across the country. The Budget requests over \$8 billion for Head Start programs, an increase of \$85 million over FY 2012, to maintain services for the 962,000 children currently participating in the program. This investment will also provide resources to effectively implement new regulations that require grantees that do not meet high quality benchmarks to compete for continued funding, introducing an unprecedented level of accountability into the Head Start program. By directing taxpayer dollars to programs that offer high-quality Head Start services, this robust, open competition for Head Start funding will help to ensure that Head Start programs provide the best available early education services to our most vulnerable children.

The Budget provides \$6 billion for child care, an increase of \$825 million over FY 2012. This funding level will provide child care assistance to 70,000 more children than could otherwise receive services

without this increased investment; 1.5 million children in total. In addition to providing funding for direct assistance to more children, the Budget includes \$300 million for a new child care quality initiative that states would use to invest directly in programs and teachers so that individual child care programs can do a better job of meeting the early learning and care needs of children and families. The funds would also support efforts to measure the quality of individual child care programs through a rating system or another system of quality indicators, and to clearly communicate program-specific information to parents so they can make informed choices for their families. These investments are consistent with the broader reauthorization principles outlined in the Budget, which encompass a reform agenda that would help transform the Nation's child care system to one that is focused on continuous quality improvement and provides more low-income children access to high-quality early education settings that support children's learning, development, and success in school.

Improve the Foster Care System: The Budget includes an additional \$2.8 billion over ten years to support improvements in child welfare. Additional resources will support incentives to states to improve outcomes for children in foster care and those who are receiving in-home services from the child welfare system, and also to require that child support payments made on behalf of children in foster care be used in the best interest of those children. The Budget also creates a new teen pregnancy prevention program specifically targeted to youth in foster care.

Child Support: The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to TANF families. Recognizing that healthy families need more than financial support alone, the proposal would also require states to include parenting time provisions in initial child support orders and increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and implement domestic violence safeguards. The Budget request also includes new enforcement mechanisms that will enhance child support collection efforts.

Strengthen TANF and Create Jobs: The Budget would provide continued funding for the TANF program and would fund the Supplemental Grants for Population Increases. When Congress takes up reauthorization, we want to work with lawmakers to strengthen the program's effectiveness in accomplishing its goals. This should include using performance indicators to drive program improvement and ensuring that states have the flexibility to engage recipients—including families with serious barriers to employment—in the most effective activities to promote success in the workforce. We also want to work with Congress to revise the Contingency Fund to make it more effective during economic downturns.

Keeping America Healthy: The President's Budget includes resources necessary to enhance clinical and community prevention, support research, develop the public health workforce, control infectious diseases, and invest in prevention and management of chronic diseases and conditions.

Million Hearts Initiative: The Million Hearts Initiative is a national public-private initiative aimed at preventing 1 million heart attacks and strokes over 5 years, from 2012 to 2017. It seeks to reduce the number of people who need treatment and improve the quality of treatment that is available. It focuses on increasing the number of Americans who have their high blood pressure and high cholesterol under control, reducing the number of people who smoke, and reducing the average intake of sodium and trans fats. To achieve this overall goal, the Initiative will promote medication management and support a network of electronic health record registries to track blood pressure and cholesterol control, along with many other public-private collaborations. In FY 2013, the Budget requests \$5 million for CDC to achieve measurable outcomes in these areas.

Preventing Teen Pregnancy: The Budget includes \$105 million in the Prevention and Public Health Fund for the Office of the Assistant Secretary for Health for teen pregnancy prevention programs. These programs will support community-based efforts to reduce teen pregnancy using evidence-based models as well as promising programs and innovative strategies. The Budget also includes \$15 million in funding for CDC teen pregnancy prevention activities to reduce the number of unintended pregnancies through science-based prevention approaches.

Protect Vulnerable Populations: HHS is committed to ensuring that vulnerable populations continue to receive critical services during this period of economic uncertainty.

ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

Enhancing Health Care Decision-Making: The HHS Budget includes \$599 million for research that compares the risk, benefits, and effectiveness of different medical treatments and strategies, including health care delivery, medical devices, and drugs, including \$78 million from the Patient-Centered Outcomes Research Trust Fund established by the Affordable Care Act. Evidence generated through this research is intended to help patients make informed health care decisions that best meet their needs. This level of funding will primarily support research conducted by NIH, core research activities within the Agency for Healthcare Research and Quality (AHRQ), and data capacity activities within the Office of the Secretary. Resources from the Trust Fund will support comparative clinical effectiveness research dissemination, improved research infrastructure, and training of patient-centered outcomes researchers. HHS core research will be coordinated to complement projects supported through the Trust Fund and through the independent Patient-Centered Outcomes Research Institute.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORK FORCE

Investing in Infrastructure: A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes \$677 million, an increase of \$49 million over FY 2012, within HRSA to expand the capacity and improve the training and distribution of primary care, dental, and pediatric health providers. The Budget will support the placement of more than 7,100 primary care providers in underserved areas and begin investments that expand the capacity of institutions to train 2,800 additional primary care providers over 5 years.

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILITY OF HHS PROGRAMS

Living Within our Means: HHS is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. The FY 2013 discretionary request demonstrates this commitment by maintaining ongoing investments in areas most central to advancing the HHS mission while making reductions to lower priority areas, reducing duplication, and increasing administrative efficiencies. Overall, the FY 2013 request includes over \$2.1 billion in terminations and reductions to fund initiatives while achieving savings in a constrained fiscal environment. Many of these reductions, such as the \$452 million cut to the Low Income Home Energy Assistance Program (LIHEAP), the \$177 million cut to the Children's Hospital Graduate Medical Education Payment Program, and the \$327 million cut to Community Services Block Grants, were very difficult to make, but are necessitated by the current fiscal environment.

In September 2011, the Administration detailed a plan for economic growth and deficit reduction. The FY 2013 Budget follows this blueprint in its legislative proposals, presenting a package of health savings proposals that would save more than \$360 billion over 10 years, with almost all of these savings coming from Medicare and Medicaid. Medicare proposals would encourage high-quality, efficient care, increase

the availability of generic drugs and biologics, and implement structural reforms to encourage beneficiaries to seek value in their health care choices. The Budget also seeks to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the FY 2013 discretionary budget request and these legislative proposals allow HHS to support the Administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Program Integrity and Oversight: The FY 2013 Budget continues to make program integrity a top priority. The Budget includes \$610 million in discretionary funding for Health Care Fraud and Abuse Control (HCFAC), the full amount authorized under the Budget Control Act of 2011 (BCA). The Budget also proposes to fully fund discretionary program integrity initiatives at \$581 million in FY 2012, consistent with the BCA. The discretionary investment supports the continued reduction of the Medicare fee-for-service improper payment rate; investments in prevention-focused, data-driven initiatives like predictive modeling; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives, including Medicare Strike Force teams and fighting pharmaceutical fraud.

From 1997 to 2011, HCFAC programs have returned over \$20.6 billion to the Medicare Trust Funds, and the current three-year return-on-investment of 7.2 to 1 is the highest in the history of the HCFAC program. The Budget proposes a 10-year discretionary investment yielding a conservative estimate of \$11.3 billion in Medicare and Medicaid savings and 16 program integrity proposals to build on the Affordable Care Act's comprehensive fraud fighting authorities for savings of an additional \$3.6 billion over 10 years.

Additionally, the Budget includes funding increases for significant oversight activities. The request includes \$84 million for the Office of Medicare Hearings and Appeals, an increase of \$12 million, to continue to process the increasing number of administrative law judge appeals within the statutory 90-day timeframe while maintaining the quality and accuracy of its decisions. The Budget also includes \$370 million in discretionary and mandatory funding for the Office of Inspector General (OIG), a 4 percent increase from FY 2012. This increase will enable OIG to expand CMS Program Integrity efforts in areas such as HEAT, improper payments, and focus on investigative efforts on civil fraud, oversight of grants, and the operation of new Affordable Care Act programs.

Additionally, Durable Medical Equipment (DME) Competitive Bidding is providing competitive pricing, while continuing to ensure access to quality medical equipment from accredited suppliers, which will save Medicare \$25.7 billion over 10 years and help millions of Medicare beneficiaries save \$17.1 billion in out-of-pocket costs over 10 years. The Budget proposes to extend some of the efficiencies of DME Competitive Bidding to Medicaid by limiting Federal reimbursement on certain DME services to what Medicare would have paid in the same state for the same services. This proposal is expected to save Medicaid \$3.0 billion over 10 years.

COMPLETING IMPLEMENTATION OF THE RECOVERY ACT

The American Recovery and Reinvestment Act provided \$140 billion to HHS programs, of which \$110 billion had been spent by grant and contract recipients by the end of FY 2011. The vast majority of these funds helped state and local communities cope with the effects of the economic recession.

Thousands of jobs were also created or saved, including subsidized employment and training for over 260,000 people through the Temporary Assistance for Needy Families (TANF) program Emergency Contingency Fund.

The Recovery Act provided states fiscal relief through a temporary increase in Federal matching payments of \$84 billion for Medicaid and foster care and adoption assistance.

HHS Recovery Act funds are also making long-term investments in the health of the American people and the health care system itself. Beginning in FY 2011 and continuing for the next few years, HHS will be investing more than \$20 billion to support implementation of health information technology in the health care industry on a mass scale. This effort is expected to significantly improve the quality and efficiency of the U.S. health care system. In addition, \$10 billion in Recovery Act funds were invested in biomedical research programs around the country, including a major effort to document genomic changes in 20 of the most common cancers and to build research laboratory capacity. Of more immediate impact, \$1 billion has been supporting prevention and wellness programs, including projects in 44 communities with a total combined population of over 50 million aimed at reducing tobacco use and the chronic diseases associated with obesity.

HHS has also met the challenges of transparency and accountability in the management of its Recovery Act funds. More than 23,000 grantees and contractors with Recovery Act funding from HHS discretionary programs have submitted reports on the status of their projects over the last 10 quarters. More than 99 percent of the required recipient reports have been submitted on time and are available to the public on Recovery.gov; non-filers have been sanctioned. Finally, HHS Recovery Act program managers are working hand-in-hand with the Secretary's Council on Program Integrity to ensure that risks for fraud, abuse, and waste are identified and steps are taken to mitigate those risks.

Thank you for the opportunity to testify. I will be happy to answer any questions you may have.

**Senate Committee on Finance Hearing
February 15, 2012**

“President’s Fiscal Year 2013 Health Care Proposals”

**Hon. Kathleen Sebelius
Secretary, Department of Health and Human Services**

Responses to Questions for the Record From Committee Members

The Honorable Maria CantwellChildren's Hospitals Graduate Medical Education

Secretary Sebelius, in its Performance Index to its Fiscal Year 2012 Budget, the Health Resources and Services Administration (HRSA) notes the continuous yearly growth (from 3 percent to 6 percent) in the number of resident full-time equivalents (FTEs) at freestanding children's hospitals since the inception of the Children's Hospitals Graduate Medical Education (CHGME) Program in 1999. The report also notes that the CHGME Program has helped to expand access to pediatric care for underserved children by expanding the health care safety net. Secretary, I have a few questions regarding the CHGME Program, especially in light of this report and the President's fiscal year 2013 proposed budget:

1. Do you agree that the CHGME Program has been successful?

Answer: CHGME was created to address a specific gap with respect to federal support for residency training at children's hospitals, and has been successful in doing so. In academic year 2010-2011, the CHGME payment program supported approximately 6,000 full-time equivalent (FTE) residents at 55 eligible children's hospitals in 30 states and Puerto Rico. Approximately 46 percent of supported FTE residents were training in pediatrics, 28 percent in pediatric subspecialties, and 26 percent were non-pediatric residents on rotation. The proposed cut is not a reflection of the success of the program.

2. How will the Administration help preserve these important residency programs in light of the Administration's proposed funding cuts?

Answer: The FY 2013 Budget request of \$88,000,000 will support the direct portion of graduate medical education payments for participating institutions. Given this continued support, the elimination of IME payments in the CHGME program for FY 2013 may not have a substantial impact on the number of residents trained as programs have infrastructure in place to support specific residency class size. HRSA administers a number of workforce programs that support pediatric residency training, including the Primary Care Residency Expansion Initiative, the Primary Care Training and Enhancement Program, and the Teaching Health Center GME Program. We encourage eligible institutions to apply for these funding opportunities to help support the training of pediatric residents.

For instance, the CHGME Program was slated for complete elimination in the President's fiscal year 2012 budget, and in his fiscal year 2013 budget proposal, the President would fund the CHGME program at \$88 million, a 67 percent reduction below the level that Congress funded the program at in 2012, and far below the Program's current annual funding level of about \$270 million. The CHGME program funds the training of 45 percent of all pediatricians and 50 percent of all pediatric specialists. Any cuts to this funding will be detrimental to the future pediatric workforce.

Secretary, I am also concerned about the proposed funding level's impact on access to pediatric care. This low funding level coincides with a growing child population and a

workforce unable to keep up with population demands. According to the Children's Hospital Association, this is resulting in impaired access to pediatric care, delayed care, longer wait times, and longer distances for families to travel in order to receive care.

3. Can you speak about any action the Administration is taking in light of this proposed funding level's impact on access to pediatric care and the possible negative impact on children's health outcomes?

Answer: HRSA will continue to support pediatric residency training through the Primary Care Residency Expansion Initiative, the Primary Care Training and Enhancement Program, the Teaching Health Center GME Program, and the financial support of direct medical education costs in the CHGME payment program.

Additionally, research has indicated that there is a significant shortage of pediatric specialists, resulting in children with serious illnesses being forced to travel long distances – or wait long periods—to see a pediatric specialist. In response to these shortages, the President's FY 2013 Budget includes \$5 million for the Pediatric Specialty Loan Repayment (PSLR) Program. Under this program that was authorized in the Affordable Care Act, HHS may enter into loan repayment agreements with pediatric specialists who agree to work in underserved areas. Repayments would go to individuals who agree to be employed full-time for no less than 2 years in providing pediatric medical subspecialty, pediatric surgical specialty, or child or adolescent mental and behavioral health care.

The Honorable Tom Carper

Psychotropic Drugs and Foster Care Children

In December of last year, I chaired a hearing of the Senate Subcommittee on Federal Financial Management that looked specifically at the overprescribing of medications for foster care children. In its testimony, the Government Accountability Office (GAO) detailed strong evidence of widespread overprescribing of psychotropic drugs, medications intended to affect the central nervous system in order to change behavior or perception, such as anti-depressants and anti-psychotics. The GAO found that foster children were all too often prescribed psychotropic drugs, paid for by Medicaid, at much higher rates than were non foster children. Other findings of the hearing showed the prescribed levels of these medications dangerously out of step with medical standards.

1. In general, are there steps or initiatives that the Department is considering in order to ensure that the HHS Administration of Children and Families, the Centers for Medicare and Medicaid Services, and other relevant federal agencies and offices work together effectively for foster care children, and that their prescribed medications follow best practices and medical standards?

Answer: The Department of Health and Human Services has undertaken a comprehensive effort to address the issues addressed in both the GAO report and several other studies of psychotropic medication use among children in foster care. In accordance with the Child and Family Services Improvement and Innovations Act of 2011, States are required to submit descriptions of protocols planned or in place for monitoring and oversight of psychotropic medication use in this population; these descriptions are due beginning in June 2012. To support States in developing and implementing these plans, an interagency workgroup has been convening for the past six months, sharing ongoing and anticipated Federal activities in this area and identifying opportunities for alignment and collaboration. The workgroup is comprised of representatives from ACF, CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Mental Health (NIMH). In addition to surveying existing authorities and aligning activities, the group convened a panel of experts to discuss the most current research and practice guidelines pertaining to psychotropic medication use among children in foster care.

2. Similarly, are there steps or initiative that the Department is considering to ensure that state foster care programs and Medicaid agencies work together effectively for any such improvements?

Answer: In November 2011, the Acting Assistant Secretary of ACF, the CMS Administrator, and the SAMHSA Administrator disseminated a joint letter to State child welfare, Medicaid, and mental health authorities outlining the work of the interagency group and previewing upcoming activities to support State efforts to strengthen monitoring and oversight of psychotropic medications for children in foster care. These activities include: (a) the provision of technical assistance to State child welfare, Medicaid, and mental health authorities; (b) issuance of an Information Memorandum and a Program Instruction to State child welfare authorities regarding

State plan submissions; and (c) hosting a Summit that will bring together child welfare, Medicaid, and mental health directors from all 50 States, the District of Columbia, and Puerto Rico to strengthen collaborative efforts in this area.

3. Please provider timelines and target dates for these steps or initiatives.

Answer: To address this need and to help States with the development of the psychotropic medication oversight and monitoring components of their title IV-B plan, ACF, in collaboration with SAMHSA and CMS, is providing multiple opportunities for technical assistance (TA) and peer-to-peer information sharing. A three-part webinar series, hosted in January and February of this year, provided an overview of the topic, described the issues and challenges, and highlighted two approaches to medication monitoring. These webinars were recorded and are available for download and playback on the Child Welfare Information Gateway (<http://www.childwelfare.gov/aboutus.cfm>). A second webinar series is primarily targeted toward State leaders who will be working together to develop plans to enhance oversight and monitoring. These sessions will be in a question-and-answer format, allowing experts in the field to provide ideas and feedback designed to support States in their planning efforts. The first two sessions (March 28 and April 24) offered a discussion of major content areas to be addressed in State plans, while the third (scheduled for June 5) will provide an opportunity for interaction with representatives of ACF.

The Information Memorandum has been drafted and is currently in the clearance process. ACF anticipates that it will be released in early spring. The Program Instruction will be released in advance of State plan submissions.

The summit, *Because Minds Matter: Collaboration to Strengthen Management of Psychotropic Medications for Children in Foster Care*, will take place on August 27-28, 2012 in Washington, DC. The Children's Bureau is sponsoring the participation of State teams comprised of two representatives each from child welfare, mental health, and Medicaid. This will be a working meeting in which decision-makers and content experts from these three systems will learn from their peers and develop action steps for enhancing their psychotropic medication oversight plans. Technical assistance following this meeting will support State implementation of their plans.

4. Is guidance or rule changes for the Medicaid program under consideration by the Centers for Medicare and Medicaid Services regarding psychotropic medications, especially for children, to encourage the following of medical best practices, including for reimbursement rules for such medication?

Answer: As shared in December, in advance of June 2012, the ACF Children's Bureau will publish guidance documents providing information about the use of psychotropics with children in foster care and detailing the information that will be requested of States in their Annual Progress and Services Review medical oversight submissions. Key considerations, exemplary practices from around the country, and technical assistance resources will be provided to guide State's work and inform their responses to the enhanced APSR items.

Additionally, SAMHSA and the American Academy of Child and Adolescent Psychiatry (AACAP) are finalizing guidelines for the use of psychotropic medications among children and adolescents being served in community-based agencies. These guidelines are for service providers and agency leaders to assist them in developing policy about the role of psychotropic medications in treatment planning for children and youth. These guidelines will be relevant to providers working with youth in foster care and will be disseminated to groups listed below.

5. Is guidance to states under consideration by the Department to improve the monitoring of psychotropic and other medications reimbursed under the Medicaid program, including children under the foster care program?

Answer: Yes. As shared with you in December and in our November 23, 2011 tri-Agency letter¹ to State Directors on this issue, CMS is considering new guidance to assist States in their efforts to monitor the utilization of psychotropic drugs dispensed by pharmacies and will be soliciting State input on what practices would be most helpful to address the special challenges of treating this population with psychotropic medications.

In addition, CMS, through its Pediatric Quality Measures Program (PQMP), established in collaboration with the Agency for Healthcare Research and Quality (AHRQ), developed a measurement set, released in 2010 for voluntary use by Medicaid and CHIP programs, that includes three measures related to behavioral health (Follow-up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication, Follow-up after Hospitalization for Mental Illness, and Developmental Screening in the First Three Years of Life).

6. Are there any technical challenges based on the current state-level Medicaid drug related data systems for improved monitoring of such drug use? If so, what improvements to state level Medicaid data systems are necessary?

Answer: States may use their Drug Utilization Review (DUR) programs to monitor dispensing at the point of service and influence prescriber behavior. For instance, at the point of service, the DUR programs can use system edits to limit inappropriate dosage and polypharmacy. In addition, States can use their retrospective DUR programs to reach out to providers whose prescribing habits vary significantly from recommended standards of care for children. CMS is developing a process for sharing with States the best and most innovative practices to enhance the functionality of their pharmacy programs. Additionally, CMS is considering new guidance to assist States in their efforts to monitor the utilization of psychotropic drugs dispensed by pharmacies and will be soliciting State input on what practices would be most helpful to address the special challenges of treating this population with psychotropic medications.

Further, CMS is dedicated to improving the continuity of care for foster children with Medicaid. Children who move from one placement to another typically remain eligible for Medicaid, but they may nonetheless see gaps in eligibility and disruptions in their care. Working with States, ACF, health care providers, and others, CMS will identify and communicate strategies to States

¹ <http://www.cms.gov/smdl/downloads/Tri-Agency%20Letter.pdf>

for ensuring continuity of eligibility and care for children moving in and out of foster care, or between placements.

Improving the availability and functionality of EHRs is one important way of addressing issues with continuity of care. Medicaid incentive payments are available at States' option to certain providers who adopt, implement, upgrade, or meaningfully use certified EHR technology. EHRs are used to capture clinical quality measures, such as those developed by CMS, AHRQ and SAMHSA for children and behavioral health.

Community Health Centers

Community health centers are a crucial safety net, providing comprehensive primary and preventive health care for millions of people who are uninsured or underinsured.

It is my understanding based on my conversations with the superb community health centers in Delaware that despite the investments we've made in health centers in recent years, the demand for primary care in underserved areas is still great and there are more than 1800 applications pending currently for health center expansion.

7. As we ask community health centers to meet the escalating health care needs of underserved communities, how can we make sure community health centers have access to capital and adequate funding opportunities to meet this rising demand?

Answer: HHS has awarded grants to health centers for capital development purposes under both the Recovery Act and the Affordable Care Act. Five capital programs are administered by HHS' Health Resources and Services Administration (HRSA).

- The Recovery Act Capital Improvement Program (CIP) provided \$851 million in grants for health centers. With these funds, health centers were able to address immediate and pressing facility and equipment needs and create much needed health center and construction-related jobs.
 1. These grants supported the construction, repair and renovation of over 1,500 health center sites nationwide to help these centers expand and upgrade their existing facilities.
 2. More than 650 health centers used the funds to upgrade equipment and purchase HIT systems, and nearly 400 health centers promoted the expansion and adoption of electronic health records.
- The Recovery Act Facility Investment Program (FIP) addressed major capital improvement needs in health centers, including renovation, modernization, and construction projects. In FY 2010, a total of \$520 million in Recovery Act funding was awarded to 86 CHCs in 30 states, the District of Columbia, and Puerto Rico.
- The Affordable Care Act Capital Development Program (CD) provided \$732 million to 144 CHCs across the country in FY 2011. These grants, like the FIP awards, are addressing major health center construction and renovation needs and expanding access

to care. These funds were the first in a series of community health center awards made available under the Affordable Care Act, building on the \$2 billion Recovery Act investment.

- Through the Affordable Care Act, the Health Center Capital Development - Building Capacity (CD-BC) Program will provide approximately \$600 million to an estimated 125-150 health centers to improve their capacity to provide primary and preventive health services to medically underserved populations. Announcements are anticipated in Spring 2012.
- Through the Affordable Care Act, Health Center Capital Development - Immediate Facility Improvements (CD-IFI) Program will provide approximately \$100 million to an estimated 250 health centers to address immediate facility needs within existing health center sites. Announcements are anticipated in Spring 2012.

8. The loan guarantee program for community health centers under HRSA has been underutilized. Can you recommend ways to update and improve the loan guarantee program for community health centers?

Answer: The Health Center Loan Guarantee Program (LGP) administers loan guarantees both for managed care networks and plans and for health center facility projects. The LGP for facility projects makes guarantees available for loans made by non-Federal lenders for the construction, renovation, and modernization of medical facilities that are owned and operated by HRSA-funded health centers. The loan guarantee provided through the Program provides applicants a guarantee of up to 80% of the outstanding loan principal amount. To date, 25 loan guarantees have been issued by HRSA, providing approximately \$130 million in health center capital financing. In the past 2 years, the LGP has experienced growth in the use of the program, resulting in 6 capital projects supported by HRSA loan guarantees. HRSA will continue to provide eligible entities with information and guidance on accessing the LGP to increase utilization of this vital program.

Funding for Alzheimer's Disease

Alzheimer's disease is a devastating disease that is currently affecting 5.1 million Americans. This has been an issue that has been close my heart for some time, and I authored a provision in the Affordable Care Act that will allow seniors on Medicare to receive a free physical every year, that will include a screening for cognitive disease such as Alzheimer's. I want to commend the Administration for recognizing the urgency of this issue, and for the recent announcement that \$50 million would be immediately available to the National Institute of Health for research to identify treatments for Alzheimer's, and hopefully a cure. It is estimated that over 10 million Americans are caring for a family member with Alzheimer's. These networks of family caregivers are critical support systems to Alzheimer's patients.

9. Can you discuss the efforts the Administration is undertaking to support these family and community caregivers?

Answer: The Administration on Aging (AoA) administers person-centered assistance for family caregivers and persons with Alzheimer's through targeted community-based programs as well as some activities focused on those in institutional care. The National Family Caregiver Support Program, as part of the Older Americans Act, provides a number of services to caregivers of older adults, including those with Alzheimer's disease (AD and related dementias). These include: information to caregivers about available services; assistance to caregivers in gaining access to the services; individual counseling, organization of support groups, and caregiver training; respite care, and; supplemental services.

The Lifespan Respite program, authorized by the Public Health Services Act, allows us to work with state respite care coalitions through a competitive grants program to ensure that targeted populations of caregivers that assist underserved populations across the lifespan, including those with AD, have access to needed respite services.

AoA also administers the Alzheimer's Disease and Supportive Services Program of the Public Health Services Act which provides competitive grants to states designed to enhance their efforts to implement innovative and evidence-based programs which serve individuals with AD and their caregivers.

Through these programs and other collaborative activities we are working with states, localities, the faith-based community and families to expand our efforts to identify and support proven, evidence-based assistance that can best address the individual needs of caregivers of persons with AD.

For over a year, HHS has been implementing the National Alzheimer's Project Act, which calls for the creation of an Advisory Council to make recommendations on priority actions and a national plan to overcome Alzheimer's disease. The Advisory Council on Alzheimer's Research, Care, and Services, which includes two caregivers, in addition to ten other members of the public, was created in May 2011.

In January 2012 HHS released the Framework for the National Plan to Address Alzheimer's Disease. One of the goals of this plan is to "Expand Supports for People with Alzheimer's Disease and Their Families." In the Draft National Plan to Address Alzheimer's Disease, released in February 2012, HHS outlined the steps to achieve this goal, including (but not limited to) providing training and materials to caregivers and people with Alzheimer's disease, providing supports to assist caregivers, and helping families plan for future care needs. The National Plan to Address Alzheimer's Disease is expected to be released in early May.

In February, Secretary Sebelius announced that \$56 million were immediately invested in additional Alzheimer's disease activities. The National Institutes of Health (NIH) dedicated an additional \$50 million to Alzheimer's research. The Administration also committed \$6 million from the Prevention and Public Health Fund towards the healthcare provider outreach and education initiative and a public awareness and education initiative (\$4 million). In FY2013, the Administration plans to allocate \$10 million from the Prevention and Public Health Fund to the Administration on Aging (AoA) to support informal caregivers by building and strengthening the dementia capability a number of states, tribal entities, or large localities.

Health Insurance Exchanges

In the President's 2013 budget, the Administration has requested a \$1 billion increase in funding for the Center for Medicare and Medicaid Services, bringing the total CMS budget to \$4.8 billion in 2013. CMS Acting Administrator Marilyn Tavenner has said that \$868 million of this \$1 billion increase will pay for federal efforts to create health insurance exchanges for states that decide not to develop their own exchange.

The Health Insurance Exchanges, which were put in place by Congress when we passed the Affordable Care Act in 2010, will be essential components of our healthcare system in 2014 and will be the place that millions of Americans go to purchase health insurance.

10. Can you outline specifically how the \$868 million will be allocated within CMS to establish the federal health insurance exchanges for states and can you describe what the additional funding resources will be used for?

Answer: As with the State-based Exchanges, FY 2013 is the year many operations of the Federally-facilitated Exchanges begin, so that CMS will need to be prepared for open enrollment on October 1, 2013. The majority of the \$864 million request for CMS' Exchange work is related to operations and management of the Federally-facilitated Exchanges with some funding to support the Secretary's duties on behalf of all Exchanges. Specifically, \$574.5 million of the total is slated to be used for Exchange operations and management including eligibility and enrollment functions, certifying health insurance plans as qualified to be offered through the Exchange, as well as oversight of plans and State-based Exchanges. The additional \$289.5 million is slated to be used for consumer education and outreach activities, such as a call center, to help consumers understand their new options under the Affordable Care Act and to fund navigators and in-person enrollment assistance to facilitate the enrollment process.

Home Health Co-Payments

The President's budget included a proposal to introduce a home health co-payment for new beneficiaries of \$100 per home health episode originating from community-based care settings. The Department of Health and Human Services has stated that this proposal aims to "encourage the appropriate use of home health services while protecting beneficiary access."

As you may know, Congress eliminated the home health co-pay in 1972 to encourage the use of less costly, non-institutional healthcare services. Compared to a stay in a skilled nursing facility or a hospital the cost of home health services is significantly less expensive to the Medicare program.

11. Has the administration conducted an analysis to determine whether the reduction in utilization of home health services as a result of the proposed co-payment could result in a cost-shift to other care settings? If so, please describe the results of that analysis.

Answer: The Administration's proposal is consistent with MedPAC's recommendation to establish a modest copayment for certain home health episodes. The proposal includes exceptions for beneficiaries using services immediately following a hospitalization or other inpatient post-acute care stay and for low utilization of services within an episode. The proposal is designed to encourage clinically appropriate utilization of home health and other services.

12. Can you describe what steps the Department of Health and Human Services has taken to determine the potential impact this proposed co-payment could have on patient access to medically necessary home health services?

Answer: Home health services represent one of the few areas in a fee-for-service Medicare that does not currently include some beneficiary cost-sharing. The Department believes that the proposal contains appropriate safeguards to ensure that beneficiaries maintain access to medically necessary home health services while encouraging beneficiaries to consider the value home health services provide.

The proposal would create a \$100 co-payment for each home health episode, which according to MedPAC research, would equate to less than \$9 per home health visit for the average episode of care in 2008, less than the beneficiary cost-sharing for a typical outpatient management or therapy visit. Additionally, the proposal includes exceptions for beneficiaries using services immediately following a hospital or other inpatient post-acute stay and for low utilization of services within an episode of care (less than five visits).

Obesity

Obesity places an enormous burden on our health care system, costing our country more than \$147 billion dollars each year. In Delaware alone, 4 out of every 10 children are overweight or obese. Unless we find effective ways to reduce the population of overweight and obese individuals in our country, the cost of treating preventable chronic conditions such as diabetes, heart disease, high blood pressure, and other conditions will continue to overwhelm Medicare, Medicaid, and our private health system.

In the President's budget, the largest proposed cut within the Department of Health and Human Services was an 11 percent reduction to the budget authority of the Center for Disease Control and Prevention. This included a reduction of \$80 million to the Community Transformation Grants, which aim to support community-level efforts that reduce incidences of chronic diseases that are often a closely related to obesity such as heart disease and diabetes. These grants also support the promotion of healthier lifestyles.

13. How did the Administration come to the decision to reduce our investment in prevention efforts in the 2013 budget and how is the Administration's commitment to reducing obesity rates reflected in the President's 2013 budget?

Answer: Chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the U.S. Historically, CDC has funded categorical programs in state health departments to address these diseases as

well as their common risk factors of obesity, poor nutrition and/or inadequate physical activity. Under the current structure, not all states are funded for these programs.

The President's 2013 Budget request consolidates seven disease-specific budget lines— heart disease and stroke; diabetes; comprehensive cancer control; arthritis and other conditions; nutrition, physical activity, and obesity; health promotion, and school health—into a single, comprehensive grant program, the Coordinated Chronic Disease Prevention and Health Promotion Program. This consolidation is intended to provide integrated services to state, tribal and territorial health departments by maximizing the reach and impact of every dollar invested by CDC to prevent chronic diseases and promote health in a variety of environments, including schools. Grantees will be required to meet measurable targets including those related to heart disease and stroke; nutrition, physical activity and obesity; diabetes; and arthritis. The budget includes an increase of \$128.699 million for this program, which would increase average awards to states from approximately \$2.6 million to approximately \$4.5 million. These increased investments will accelerate state, tribal, and territorial prevention efforts, particularly those related to obesity and the linked chronic diseases.

Because of the inter-relatedness of many common chronic diseases and their risk factors, the Coordinated Chronic Disease Prevention and Health Promotion Program will support essential public health functions at the state level including epidemiology, evaluation, policy, communications and program management. Such an approach will strengthen state based coordination and therefore improve program impact and efficiencies, provide leadership and support for cross-cutting activities and enhance the effectiveness of chronic disease prevention and risk factor reduction efforts.

The FY 2013 Budget does not reduce the number of grants for the Community Transformation Program and **will have no impact on grants supported in FY 2011, which will be continued in FY 2013. New grants will be fully funded in FY 2012 for up to four years. In FY 2013, the CTG program will continue to amplify efforts to promote healthy behaviors that control health care costs.**

14. How can we be sure our public investments in obesity reduction programs are coordinated, evidence-based and effective?

Answer: CDC is continuing work to improve the effectiveness of obesity related grant programs (nutrition, physical activity and obesity, diabetes, heart disease and stroke, cancer and arthritis) by strengthening coordination and collaboration across individual categorical programs; better defining the range of targeted science based interventions and activities that will accelerate health improvements ; and working with state grantees to identify efficiencies and improve the effectiveness of program investments.

Currently, CDC is supporting essential chronic disease public health functions and improving the coordination of chronic disease prevention in states and at CDC. These efforts include the Coordinated Chronic Disease Prevention and Health Promotion Program funded in FY 2011 that awarded funds to the 50 states, the District of Columbia (D.C.), and seven U.S. territories. The FY 2011 investments to states ranged from \$400,000 to nearly \$2,000,000. By approaching

chronic disease prevention in a more coordinated manner, CDC is enabling states to address interrelated risk factors, including nutrition, physical activity, and obesity, and to have the flexibility they need to enhance program efficiency.

In addition, CDC is working across various program areas to promote coordinated strategies in states that focus on:

- Addressing the key risk factors for chronic disease; including poor nutrition, physical inactivity and tobacco use; improving the risk factor profile of the population and ultimately avert or delay onset of type 2 diabetes; improving cardiovascular health; reducing the incidence of the major cancers; and improving quality of life for individuals with arthritis.
- Health system investments to improve risk factor detection and management and improve delivery of quality clinical and other preventive services to detect diseases early and manage conditions like high blood pressure, high cholesterol, diabetes, and cardiovascular disease.
- Clinical and community linkages to ensure individuals with or at high risk for chronic conditions have access to resources and supports to avert or better manage those conditions, including arthritis, diabetes, and heart disease. These include programs like the National Diabetes Prevention Program, chronic disease self-management programs and a number of arthritis management programs delivered in community settings.

Ensuring sufficient state capacity will be critical to improving program efforts. Overall, these program improvements have the potential to accelerate obesity prevention strategies at the state and local level, leading to greater health impact.

The Honorable Tom Coburn**Massachusetts Hospital Provision in PPACA**

In recent weeks (Jan. 18th), 19 state hospital associations voiced their opposition to a provision the Patient Protection and Affordable Care Act that benefits only hospitals in Massachusetts at the expense of hospitals in the 49 other states. According to the hospital associations' letter, hospitals in 49 states will see their Medicare rates slashed by \$3.5 billion over the next 10 years to pay for the this provision that overrode Medicare's rules regarding hospital wage index system, providing a financial windfall for Massachusetts hospitals

1. Were you or other HHS personnel aware of this provision in the Affordable Care Act prior to enactment since HHS reviews and provides technical assistance on legislation before it's passed?

Answer: Part of our job in overseeing the Medicare program is to provide technical assistance on pending legislation at the request of Congress. As part of this routine practice, CMS provided technical assistance to Congress on this legislation prior to enactment.

2. Did you or other HHS personnel warn anyone in the hospital industry or associated lobbying organizations that this provision would reduce revenues to other hospitals?

Answer: In the August 22, 2007 Federal Register, CMS simulated the effect of two Massachusetts hospitals setting the State's rural floor and noted that the increase in payments to hospitals in that State would be budget neutral at the expense of all other hospitals paid under the inpatient prospective payment system (IPPS) nationwide. Additionally, the Medicare Payment Advisory Commission addressed this issue in its June 2007 Report to the Congress stating "The fact that the movement of one or two CAHs in or out of the [I]PPS system can increase (or decrease) Medicare payments by \$220 million suggests there is a flaw in the design of the wage index system." CMS further discussed this issue its FY 2009 IPPS rule as part of the basis for adopting a policy to apply budget neutrality for the rural floor within each State instead of nationally (See 73 FR 48570, August 19, 2008).

Finally, in the FY 2012 proposed IPPS rule, we made the public aware of what the law required and provided 60-day public comment period to provide input on the proposed rule. (See 76 FR 26059-10).

In its comments in the Federal Register last July, the Administration characterized this funneling of nearly \$4 billion in Medicare payments away from other states to Massachusetts as a 'manipulation' of the program. *Obama Administration, Federal Register, July 11, 2011:* "Hospitals in one state can expect an approximate 8 percent increase in IPPS payments due to the conversion and resulting increase of the rural floor. Our concern is that the manipulation of the rural floor is of sufficient magnitude that it requires all hospital wage indexes to be reduced by approximately 0.62 percent as a result

of nationwide budget neutrality for the rural floor (or more than 0.4 percent total payment reduction to all IPPS hospitals).”

3. Given the Administration called this a “manipulation,” do you believe this was an imprudent use of scarce taxpayer dollars?

Answer: While payments increased to Massachusetts hospitals, they were offset by a corresponding decrease in payments to other hospitals nationwide. The application of the rural floor is “budget neutral.” Therefore, overall Medicare payments neither increased nor decreased as a result of this provision.

4. Has the HHS Office of the General Counsel exhausted all avenues of possible administrative relief on this matter?

Answer: Current law is unambiguous and CMS does not have the authority to change it.

5. Will you support Congressional action to reverse this special deal? If not, why do you think it is fair to funnel \$3.5 billion away from other states’ Medicare reimbursements to give to Massachusetts providers?

Answer: Our role is to implement the law as written, and we will enforce the current law unless and until Congress changes it.

Millionaires on Medicare

The President’s Budget says that more aggressively income-relating Medicare premiums is a common-sense way to, “help improve the financial stability of the Medicare program.” However, according to government data, each year approximately 60,000 Medicare Part B enrollees report modified adjusted gross incomes of \$1 Million or more. In his most recent State of the Union, the President mentioned the proverbial “Buffett Rule” and said “Washington should stop subsidizing millionaires.” General revenues –paid by taxpayers— fund more than three-fourths of the current costs of Medicare Part B and D. Moreover, Warren Buffett can afford to pay the full cost of his Medicare Part B insurance coverage and thousands of other wealthy seniors can as well.

6. Do you support Congressional action to require Medicare Millionaires to pay the FULL cost of their premiums for Parts B and D?

Answer: The President’s Fiscal Year 2013 Budget Request proposes to reduce the Federal subsidy for higher-income Medicare beneficiaries who can most afford to pay a greater share of total Medicare costs. Reducing the Federal subsidy for this population will help ensure that Medicare remains financially secure and that current and future enrollees have access to necessary services and life-saving prescription drugs for years to come.

As you know, beneficiaries enrolled in the Medicare Part B and Part D programs are required to pay a monthly premium, which is a specific proportion of the total cost of the services that enrollees are expected to incur. Most beneficiaries pay 25 percent of the expected cost for Part B

and 25.5 percent of the expected cost for Part D. However, beneficiaries with incomes above \$85,000 (\$170,000 for couples) are required to pay a higher percentage of their Parts B and D costs, ranging from 35 percent to 80 percent. Beginning in 2017, the Administration proposes to increase by 15 percent the proportion of the benefit under Medicare Parts B and D that higher-income beneficiaries pay. Higher-income beneficiaries would pay between 40 percent and 90 percent of total estimated costs. The proposal would also maintain the income thresholds associated with income-related premiums until 25 percent of beneficiaries are subject to these higher premiums.

7. Why/why not?

Answer: The Administration supports a reduction in the Federal subsidy for higher-income Medicare beneficiaries who can most afford to pay a greater share of their Medicare costs. The Budget proposal would help ensure that Medicare remains financially secure and that current and future enrollees have access to necessary services and life-saving prescription drugs for years to come.

Medigap Changes and Individual Incentives

The President's Budget proposes introducing a Part B premium surcharge for new beneficiaries purchasing near first dollar Medigap coverage. The budget says: "Medicare requires cost sharing for various services, but Medigap policies sold by private insurance companies provide beneficiaries with additional coverage for these out-of-pocket expenses. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare costs and Part B premiums."

This proposal would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, effective in 2017. Other Medigap plans that meet minimum cost sharing requirements would be exempt from the surcharge. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium (or about 30 percent of the Part B premium). [\$2.5 billion in savings over 10 years]

8. Why did the Administration choose to put a surcharge – or tax – on Medigap coverage, rather than just prohibit first-dollar coverage? (If the concern is that low-income individuals would be impacted by cost-sharing, I'd note that 99 percent of beneficiaries can currently access a Medicare Advantage plan—which provides comprehensive coverage.)

Answer: The Administration's approach encourages beneficiaries to be active participants in their health care decisions. By incentivizing beneficiaries to choose Medigap plans under which they would bear some portion of their part B cost-sharing, beneficiaries would be more likely to purchase such plans, and thus be more likely to consider the costs of health care services, helping reduce Medicare costs (and Part B premiums). This approach maintains choice for beneficiaries by giving beneficiaries the option of purchasing these Medigap plans with a surcharge.

9. Do you agree that the fact that many seniors feel forced to buy an expensive Medigap plan is partly a sign of the fault of the Medicare basic benefit – because it does not provide catastrophic coverage in the way of a maximum out-of-pocket limit?

Answer: Beneficiaries may choose to purchase Medigap plans for a variety of reasons, depending on their individual situation and health care needs. Beneficiaries need to consider the protection from some out-of-pocket costs offered by various types of Medigap plans before determining if one of these plans will meet their needs.

10. Do you think more seniors would have better peace of mind if they knew they had a maximum out-of-pocket exposure under basic Medicare?

Answer: The Medicare program provides beneficiaries with choices and coverage to help them achieve health care security. Since its inception, the Medicare program has provided coverage that gives America's seniors broad access to high quality health care.

The President's Bipartisan Fiscal Commission proposed replacing Medicare's current mix of cost-sharing requirements with (a) single combined annual deductible covering all Part A and Part B services, (b) uniform coinsurance rate for amounts above that deductible (including inpatient expenses), and (c) annual cap on each enrollee's total cost-sharing liabilities. This could protect seniors from going bankrupt from hospital bills and severe illnesses. This would also save taxpayer dollars. CBO estimated this type of provision could reduce outlays about \$32 billion over a decade.

11. If you want to protect seniors and save taxpayer dollars, will you endorse this bipartisan proposal?

Answer: This Administration is committed to improving the financial stability of the Medicare program to ensure long-term access to its benefits for all beneficiaries. The Medicare program already does much to provide beneficiaries with health care security, but we continue to evaluate options for improving the program.

Medicare Insolvency

The Actuary of the Medicare program has warned that as soon as 2016 the Hospital Insurance Trust Fund could hit insolvency. Even under the rosy assumptions of current law, the CBO envisions insolvency in the Hospital Insurance Trust Fund by 2022.

12. Since Medicare as we know it would end when the program's Hospital Insurance Trust Fund becomes insolvent, what is the Administration's long-term plan to protect current and future seniors and put Medicare spending on a sustainable path?

Answer: This Administration is very concerned about Medicare spending, which is why the President has been focusing on reining in Medicare costs for his entire Presidency with significant success.

The FY 2013 Budget Request includes Medicare savings of approximately \$300 billion over 10 years from increasing value and efficiency in Medicare provider payments, promoting improved access to generic drugs and biologics, and enacting Medicare structural changes that will reduce Federal subsidies to higher-income beneficiaries and create incentives for new beneficiaries to seek high-value services. Together, these measures would extend the Hospital Insurance Trust Fund solvency by two years.

These reforms build on the Affordable Care Act, and achieve savings without shifting significant risk onto the individuals these programs serve, slashing benefits, or undermining the fundamental compact with our Nation's seniors or people with disabilities. The new proposals would make only gradual changes to the Medicare program, protecting both current and middle-class beneficiaries.

The Honorable Michael EnziPriorities USA Super PAC

This morning I sent a letter to President Obama asking him to reconsider his decision, and not allow you to participate in fundraising events for the new Priorities USA Action super PAC. Over the next year, you will make dozens of decisions in implementing the new health care law. These decisions will have major financial impacts on various insurers, providers, and drug and device manufacturers. Simultaneously you will be attending fundraising events, where these same entities will be asked to make major financial contributions to the President's re-election campaign. This is clearly improper and a conflict of interest.

1. If the President fails to reconsider his decision to have you participate in fundraising activities, will you recuse yourself from participating in any regulatory decisions that may affect any health care stakeholders who participate in these fundraising activities?

Answer: Invitations to speak at political events are vetted by agency counsel to ensure compliance with federal laws and regulations that govern the political activities of Senate confirmed presidential appointees. Among those rules is a requirement to ensure that the audience at any political event is not composed primarily of persons who have matters before the department, and organizations are advised of the need to have a diverse group of attendees.

EHB Bulletin

In December, the Administration published a "bulletin" on essential health benefits – the mandates that all new health plans sold to individuals and small businesses will be required to provide in 2014 and beyond. The "bulletin" fails to answer basic questions from states and employers.

2. When will you provide the details regarding benefit mandates and the other new insurance rules, so that we can know how much premiums will be raised and how much Federal costs will increase?

Answer: HHS is committed to a transparent process and providing ample opportunity for stakeholder comment and input. To that end, we released an informational bulletin in December 2011 to lay out how we intend to move forward to define an essential health benefits (EHB) package. HHS is gathering input on the bulletin, taking public input into consideration, and then will issue a Notice of Proposed Rulemaking. Additionally, HHS expects to release bulletins on cost-sharing and actuarial value in the near future.

The "bulletin" tells states they must choose among four options before September 2012. My question is will a rule be finalized before the September 2012 deadline the "bulletin" places on states?

3. How can states be expected to implement a "bulletin" which has no force of law?

Answer: HHS is committed to a transparent process and providing ample opportunity for stakeholder comment and input. To that end, the bulletin lays out how HHS intends to move forward to define an EHB package. The purpose of releasing a bulletin was to give families, employers, and States time to take this information into account as they plan for the implementation of the covered expansion in 2014, while also allowing ample opportunity for HHS to solicit public comment in advance of rulemaking. HHS does intend to issue a proposed rule in the future, but we wanted the opportunity to gather stakeholder input and we also knew it was important to signal, through this bulletin, HHS' intended approach as States head into their 2012 legislative session.

Contraceptive Coverage

Last week the President attempted to address recent controversy prompted by the Administration's mandate that religiously affiliated hospitals, schools and charities must provide contraceptives to their employees. Unfortunately, the final rule and guidance your Department published last week did not address this issue. The final rule indicated that you would issue additional rules that still require these employers to make contraceptive available and force insurance companies to pay for contraceptive services.

4. What legal basis do you have to force an insurer, as part of a private contract, to provide any item or service and not charge anything for it?

Answer: We have concluded that we legally can require insurers to both cover contraception in this way and not charge for it under new policies and plans, but this must be proposed and adopted in rulemaking. If it saves the insurers money, as the evidence indicates, then a requirement that the insurers may not charge would not be a burden.

Actuaries and experts agree that covering contraception actually saves money for insurance companies. The cost of contraception coverage is low and tends to be more than offset by the savings that result from improved health and fewer unplanned pregnancies. For example:

- A study by the National Business Group on Health estimated that it would cost employers 15-17% more not to provide contraceptive coverage in employee health plans than to provide such coverage, after accounting for both the direct medical costs of pregnancy and indirect costs such as employee absence and reduced productivity.
- When contraceptive coverage was added to the Federal Employees Health Benefits Program, premiums did not increase.
- And 22 States including and Pennsylvania have family planning waivers in Medicaid that have significantly expanded coverage of these services without increasing State or Federal costs (i.e., they are budget neutral).

As such, it is hard to argue that insurers need to raise premiums for coverage that lowers costs.

5. How will you protect the conscience rights of employers who self-insure their health benefits (where there is no insurer, who can provide the contraceptives for free)?

Answer: The regulations finalize last summer's interim final regulations on the exemption from the contraceptive coverage requirement for churches and similar organizations. The Federal Register publication also discusses the one-year transition, non-enforcement period, which is detailed in separate guidance from the Departments.

It also describes our intent to initiate a rulemaking to require insurers to offer objecting additional religious employers plans without coverage for contraceptive services and simultaneously offer the employer's plan participants contraceptive coverage (with no cost-sharing) at no additional premium. It further indicates our intent to establish a similar policy with respect to self-insured group health plans.

We expect that, after notice and comment rulemaking to be completed by August 1, 2013, these organizations will be able to take advantage of the new policy that will permit certain additional religious organizations with religious objections to contraceptive coverage to offer health coverage that does not cover contraceptives.

6. When will the Department issue more information about the President's proposal to force insurance companies to pay for these services?

Answer: The transition period for non-exempt religious organizations ends on August 1, 2013, and we intend to finalize the regulations before then and in time to allow time for religious organizations, insurance companies and plan administrators to adapt their health coverage to the final policy, as appropriate.

Drug Shortage Crisis

The Administration released an Executive Order claiming it couldn't wait for Congress to solve the drug shortage crisis. However, a recent New York Times article discusses the impending shortage of methotrexate, a crucial medicine for childhood leukemia and many other diseases.

7. If the Executive Order fixed drug shortages without Congress, why is there a new shortage?

Answer: It is important to note that not all shortages can be prevented or resolved quickly due to the significant safety and quality issues that may be involved. On February 21, 2012, FDA announced the approval of a new manufacturer of preservative-free formulation of methotrexate that would further bolster supply and help avert a shortage of this lifesaving medicine. FDA expedited review of the application to help address this potential shortage.

8. Why have the Administration's recent actions not prevented this shortage?

Answer: As noted above, not all shortages can be prevented or resolved quickly due to the significant safety and quality issues that may be involved. However, in all cases, FDA utilizes a team of experts and employs all available tools to prevent and address the shortage or disruption in supply.

9. Given the new authorities under the Executive Order, please identify what you are doing to ensure that patients will once again be able to get access to methotrexate?

Answer: In the case of methotrexate, FDA prioritized review of an application from drug manufacturer APP to make preservative-free methotrexate. Applications for drug products that are medically necessary and in shortage are given expedited review when possible. When an actual or potential shortage is reported, FDA staff check the submission queue to see if any applications can be expedited to help alleviate or prevent the shortage. We will continue to use this approach as one of many strategies to continue or restore patients' access to needed medication.

Exchanges

Unfortunately, the new health care law writes HHS a blank check and appropriates "such sums as may be necessary" to implement the state based health insurance exchanges. Your budget estimates spending \$1.087 billion in mandatory money for FY 2013.

10. Can you please tell me how much you expect the Department will spend on health insurance exchanges since the time the health care bill was signed into law until 2014 when the exchanges are supposed to be fully operational?

Answer: Our current baseline for Exchange Planning and Establishment Grants estimates that we will obligate approximately \$2.5 billion between when the law was enacted until FY 2014 and that we will outlay \$2.0 billion during that timeframe.

11. Will you commit, during this time of unprecedented federal debts and deficits, that you will cap the amount of money the federal government will spend implementing this part of the health care law?

Answer: The Administration is working to implement this portion of the Affordable Care Act as efficiently as possible. We do not believe it is necessary to establish an arbitrary cap on implementation spending at this time, but will work with Congress to describe our funding needs and present them through the budget process.

In addition to this mandatory money for state based health insurance exchanges, your budget requests an additional \$864 million for the federal exchange and other exchange activities.

12. If Congress denies this \$864 million request, will your department still pursue a federal exchange? If so, how will you fund the federal exchange?

Answer: HHS is committed to the successful implementation of Exchanges, and to ensuring that all Americans have access to affordable coverage options beginning in 2014. The request included in the FY 2013 President's Budget reflects the resources necessary to implement the Federal facilitated exchanges.

13. How will the federal exchange differ in functionality from the web portal HHS has already implemented?

Answer: The Affordable Care Act directed the Secretary, no later than July 1, 2010, to establish a web portal to provide better access to information to consumers on coverage options. The healthcare.gov portal provides summary provider information and eligibility information for various coverage options and also provides contact information for private plans, high risk pools, Medicare, Medicaid, and CHIP to help individuals enroll, and provides small business coverage options. The web portal remains a key source of information about coverage options prior to 2014 when Exchanges, including federally- facilitated exchanges, will be operational and provide competitive marketplaces for individuals and small employers to directly compare private health coverage options on the basis of price, quality, and other factors.

While both the Exchange and the web portal provide consumers access to information, they differ in many meaningful ways. Exchanges are required to undertake several functions as outlined in the Affordable Care Act section 1311(d). One of the functions is a web portal. As outlined in the final rule *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for employers* (CMS 9989-F), an Exchange, whether State-based or Federally-facilitated must comply with the requirements in section 155.130 and subparts C, D, E, H, and K of 45 CFR Part 155. These sections of the regulation encompass among other things, consumer assistance services such as the Navigator program, eligibility determinations for insurance affordability programs (Medicaid, CHIP, premium tax credits), certification of qualified health plans, and evaluation of quality improvement strategies of qualified health plans.

The health care law included a \$1 billion implementation fund. Unfortunately, the Budget only includes one page about this fund and very briefly mentions how the \$1 billion will be spent.

14. Please explain exactly how much money will be spent by HHS, the Department of Treasury, the Department of Labor, and the Office of Personnel Management on implementation of PPACA and how the funds will be expended.

Answer: Regarding the Health Insurance Reform Implementation Fund, we anticipate obligating the remaining Implementation Fund balances during FY 2012. As of February 29th, we have obligated the following amounts:

Organization	Obligations	Outlays
Internal Revenue Service	\$213,264,945	\$154,181,697
Office of Personnel Management	2,938,850	1,442,102
Department of Labor	3,055,102	2,958,880
Department of Health and Human Services	251,742,492	134,917,483
Total Health Reform Implementation Fund	\$471,001,389	\$293,500,162

Future decisions regarding the implementation fund will be made on a case-by-case basis based on policy priorities and operational needs, and subject to review by HHS.

15. Do you anticipate other agencies will be involved with implementation of PPACA?

Answer: The Social Security Administration also has statutory requirements in support of the State and Federally-facilitated Exchanges.

16. If so, what agencies and how will their PPACA implementation activities be funded?

Answer: HHS and SSA work closely on ACA implementation. Funding for SSA activities will be determined based on the availability of various funding sources.

17. The Department of Health and Human Services Budget (HHS Budget) calls for 76,341 employees in 2013. This is an increase of nearly 1,400 employees over the FY 2012 level. How many of these employees will be hired to implement the new health care law?

Answer: At the Centers for Medicare & Medicaid Service (CMS), the President's Budget requests an increase of 136 FTEs over the FY 2012 appropriated level to enable CMS to address the needs of a growing Medicare population, as well as oversee expanded responsibilities from legislation passed in recent years.

18. How many staff members are currently working at the Center for Consumer Information and Insurance Oversight (CCIIO)? Please provide numbers for both full-time and part-time staff separately.

Answer: As of 3/10/2012, CCIIO has approximately 261 employees on-board. 258 employees are considered full-time, and 3 employees are considered part-time. This staff is supported by a combination of discretionary funds and mandatory ACA funding.

19. How many staff do you expect will be working at CCIIO at the end of FY 2012?

Answer: By the end of FY 2012, CMS expects to use 450 FTEs on CCIIO-related activities. This staffing level will grow to a projected 710 FTEs by the end of FY 2013 as CMS brings the Exchanges online and implements consumer protections and other reforms.

20. How many staff do you expect will be working at CCIIO at the end of FY 2013?

Answer: See above explanation.

21. Please provide a schedule of when you expect upcoming health care regulations will be published. Also, senior Administration staff has previously indicated that many of the interim final rules will be reissued as final rules. Is this true? If so, please include the dates you expect the interim final rules will be reissued as final rules as part of the schedule mentioned above.

Answer: HHS is committed to meeting the deadlines prescribed by the Affordable Care Act and will continue to publish regulations as necessary to carry out our statutory responsibilities in a transparent and open way. While HHS has worked to manage different statutory implementation schedules, we have consistently sought, considered, and accommodated public comment.

In order to meet the ambitious deadlines in the Affordable Care Act, the Administration used interim final regulations with comment periods in some limited circumstances. We fully intend to finalize these rules as expeditiously as we can.

Shared Savings Program

The budget notes that the Medicare Shared Savings Program is expected to save \$470 million over the next 4 years. Ranking Member Hatch, Senator Coburn, and I sent a letter to you last November requesting, among other things, any estimates of savings for this program prepared by the CMS Actuary. We have yet to receive a response to this letter. Therefore, we request that you please provide the following information and documents:

22. An accounting of expenditures made to date by the Innovation Center to test payment and service delivery models. Identify all recipients of funding from the Innovation Center to date, including how much each entity received and for what purpose. This includes, but is not limited to, expenditures made under the Partnership for Patients, the Bundled Payments for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) program, and the Physician Group Practice Transition Demonstration.

Answer: See answer to Question 25 below.

23. Any strategic plan or operating strategy document that provides information on future initiatives funded by the current \$10 billion appropriation for the Innovation Center. Please include any studies, analysis or supporting documentation that supports the need for those initiatives and the anticipated value they will add to the Medicare program.

Answer: The statutory mandate of the Innovation Center is to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for Medicare, Medicaid or CHIP beneficiaries. The Innovation Center has developed a Mission Statement, Process Statement, and Portfolio Criteria (March 2011) that collectively explain the Innovation Center's strategy, which are all publically available on the Innovation Center's website¹.

The Innovation Center's mission² is to help transform the Medicare, Medicaid and CHIP programs to deliver better health care, better health and reduced costs through improvement for CMS beneficiaries and in so doing, help to transform the health care system for all Americans. The Innovation Center carries out this mission by identifying, testing and fostering new models of care and payment.

The Innovation Center has established a Process Statement³ and Portfolio Criteria for identifying, developing, and advancing a balanced portfolio of care delivery and payment initiatives consistent with its mission and authority. This process includes soliciting ideas for new models, selecting the models that show promise to improve quality and reduce costs, testing and evaluating the models, and expanding the use of the models as authorized under the statute. Two of the most important parts of the Innovation Center's process are obtaining ideas from the public through website submissions and holding listening sessions to engage stakeholders and stimulate discussion about innovative ideas. The Innovation Center has met with hundreds of people and organizations, held 10 regional meetings with over 4,000 attendees, and received nearly 500 significant suggestions for improving health care payment and delivery through the "Innovation Pipelines" on our website. Staff are reviewing these ideas to determine the innovations with the most promise. The Innovation Center has made it a priority to meet with stakeholders from all around the country.

During the review of each potential model, the Innovation Center evaluates the model's evidence base to determine whether the model has an appropriate business case by reviewing the potential cost and quality impact of the initiative. The review includes an evaluation of the strength of the evidence and scalability of the model. For those initiatives with promise, the Innovation Center reviews the available literature, analysis, and documentation supporting the need for the initiative. Typically, in consultation with the CMS Office of the Actuary, the Innovation Center prepares estimates of the financial impact of the proposed initiatives, as well as an analysis of their potential impact on the quality of health and health care among beneficiaries, an examination of current costs of the targeted health care service, an analysis of the potential savings, and a review of the prior research that supports testing the initiative.

¹ <http://innovations.cms.gov/>

² <http://innovations.cms.gov/About/Our-Mission/index.html>

³ <http://innovations.cms.gov/About/Our-Process/index.html>

Initiatives go through a structured clearance process to ensure that the initiative's premise is fiscally sound, that it meets the statutory requirements, and that it shows the promise of delivering better health care and lower costs.

24. An explanation of the organizational structure of the Innovation Center. List the individuals employed by the Innovation Center, including names, titles, job requirements, SES or grade level, and salary. In addition, please describe the statutory or other authority under which these employees were hired and the Innovation Center's annual expenditures for salaries, travel, training, office space, technology and all other costs associated with personnel. Please include a detailed description and/or visual representation of the organizational structure of the Innovation Center that details all groups, divisions or other hierarchies that exist. Also provide any information regarding pilot projects or other initiatives related to personnel within the Innovation Center.

Answer: To coordinate initiatives, demonstrations, and research projects at CMS and to prevent duplication, the Innovation Center oversees initiatives that are authorized and funded under various authorities, including those from the Affordable Care Act as well as other statutes. As of January 14, 2012, the Innovation Center has a total of 106 full time equivalents (FTEs) paid through Section 1115A(f) of the Social Security Act and 48 FTEs funded from other authorities for a total of 154 FTEs.

25: A detailed breakdown of the budget of the Innovation Center including all monies spent since the office's inception and future spending for FY 2012 that clearly delineates administrative and operational costs. Please also include a listing of all anticipated contract actions and actual awards made from the Innovation Center's inception through FY 2012.

Answer: The table below lists the Innovation Center's obligations for FY 2011 and through March 31, 2012, detailing direct spending on testing payment and service delivery models, support for general model operations, and administrative expenses, with respect to activities conducted under the authority of Social Security Act section 1115A (section 3021 of the Affordable Care Act).

Obligations <i>(dollars in millions)</i>	2011 Actual	2012 To date
Innovation Models	51	244
Innovation Supports	23	17
Administrative Expenses	21	10
Total	95	270

In FY 2011 the Innovation Center obligated \$95 million in expenditures, \$44 million (46%) of which was for Innovation supports and administrative costs for the Center's first year of operation. For FY 2012, a much larger percentage of spending is projected to be on specific models.

To coordinate initiatives, demonstrations, and research projects at CMS and to prevent duplication, the Innovation Center oversees initiatives that are authorized and funded under various authorities separate from section 1115A of the Social Security Act, including demonstrations formerly conducted by the CMS Office of Research, Development, and Information (ORDI). Many of the staff from the former ORDI were reassigned to the Innovation Center in March 2011. The table below includes funding from all other sources.

Innovation Center Activity <i>(dollars in millions)</i>	FY 2011 Actual Obligations	FY 2012 Obligations as of 3/31/2012
Other Demonstrations and Evaluations ¹	\$50	\$0.8
Administrative Expenses ²	\$5 ³	\$4
Total, Other Funding (not including Social Security Act § 1115A funding)	\$54	\$4

1/ Demonstrations and evaluations conducted under the authority of the Affordable Care Act (with the exception of funding under section 1115A of the Social Security Act), other statutory authority, or under section 402 of the Social Security Amendments of 1967.

2/ The FY 2011 actual and FY 2012 expenditures and obligations as of 12/31/11 are the administrative costs associated with the former CMS Office of Research, Development and Information (ORDI).

3/ Many of the staff from the former ORDI were reassigned to the Innovation Center in March 2011; therefore, FY 2011 reflects costs of these staff from March 2011 through September 2011 only.

CMS continues to compile a responsive answer to your November request for contracts and awards. We look forward to delivering shortly.

26. Any estimates of savings prepared by the CMS Office of the Actuary for programs developed by the Innovation Center to date or any evidence that participants in these programs are generating Medicare spending that is lower than the median fee-for-service (FFS) provider or lower than how the median FFS provider would have performed as a result of the Partnership for Patients, the Bundled Payments for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the FQHC Advanced Primary Care Practice Demonstration, the Medicare Shared Savings Program, the Pioneer ACO program, the Physician Group Practice Transition Demonstration, and other Innovation Center programs.

Answer: During the review of each potential model, the Innovation Center evaluates the model's evidence base by reviewing the potential cost and quality impact of the initiative. The review includes an evaluation of the strength of the evidence and scalability of the model. For those initiatives with promise, the Innovation Center reviews the available literature, analysis, and documentation supporting the need for the initiative. Typically, in consultation with the CMS Office of the Actuary, the Innovation Center prepares estimates of the financial impact of the proposed initiatives, as well as an analysis of their potential impact on the quality of health and

health care among beneficiaries, an examination of current costs of the targeted health care service, an analysis of the potential savings, and a review of the prior research that supports testing the initiative.

27. Any specific metrics and measures to be used by the Secretary to evaluate the impact of these initiatives and programs on reducing Medicare spending, improving the quality of care, or improving beneficiary access to care, including any internal CMS or HHS guidance.

Answer: An evaluation of the model's performance is planned for each model tested by the Innovation Center. The evaluation is intended to determine whether a model would lead to spending reductions, improvements in the quality of care delivered, and/or better patient health outcomes and experiences. The Innovation Center will align its relevant performance measures to those from the HHS National Strategy for Quality Improvement in Health Care as well as measures used for other CMS programs, such as those used for the Physician Quality Reporting System and the Medicare Shared Savings Program.

All participating providers will be required to work with an independent evaluator to track and provide agreed-upon data as needed for the evaluation. As applicable, these data will be merged with administrative claims data collected by CMS to allow assessment of performance on topics such as clinical quality performance, patient functional status, and financial outcomes. The Innovation Center anticipates using multiple cycles of data collection due to the changing nature of the approaches used by participants in response to rapid-cycle feedback. Particular care will be taken to identify the effect of each reform in the context of other interventions.

For example, when evaluating participants in the Comprehensive Primary Care initiative, the Innovation Center will review several types of quality and patient experience measures. These measures will include the following domains: patient and caregiver experience, care coordination and care transitions, preventive health, at-risk populations, and practice transformation. The Innovation Center will use well-established quality measures that are currently part of other CMS and HHS initiatives but also recognizes that a variety of other measures exist and may be appropriate to evaluate participants in this initiative. Market-level discussions with participants in the Comprehensive Primary Care initiative will drive harmonization of any additional quality measures and reduce administrative burden to participating practices through a shared approach to quality improvement.

SEIU

Recent media reports have revealed that parents and other individuals who serve as caregivers for disabled individuals and receive Medicaid subsidies to provide care to these family members are classified as "public employees" by certain state agencies. This classification results in the state, in conjunction with the Service Employees International Union (SEIU), deducting a portion of the monthly Medicaid subsidy provided to these families as "union dues."

28. Is CMS aware of this practice? How many states operate this type or similar arrangements?

Answer: CMS takes our Medicaid oversight responsibilities seriously, and works to ensure that federal dollars are spent appropriately through our oversight and approval of State Medicaid plans, waivers, estimated and actual State expenditures, and other State actions.

The 1915(c) Home and Community Based Services (HCBS) waiver program allows for a State to make payment to “legally responsible” relatives (spouses, parents or legal guardians of minors) under specific circumstances per the terms of the State’s waiver application; however, this is an individual decision of each State. Federal Medicaid law and regulations impose certain restrictions or conditions that must be met for States to allow legally responsible relatives to be paid caregivers, which CMS enforces through the State Medicaid plan amendment and HCBS waiver approval processes.

CMS does not keep statistics or otherwise become involved in issues related to the unionization of home care or other health care workers.

According to the Dartmouth Atlas, costs of care for patients in rural areas are lower than equivalent costs of treatment for similar patients and similar conditions in urban areas.

29. Why then, when the Administration is seeking to create incentives for providers who provide value, not volume of care, does your budget cut billions of dollars in payments for rural providers?

Answer: The Administration greatly values the critical work of rural providers, who provide essential health services to many underserved rural communities. I believe this question may be referring to two proposals in the President’s Fiscal Year 2013 Budget Request: 1) to prohibit hospitals that are ten miles or less from the nearest other hospital from maintaining designation as Critical Access Hospitals (CAH); and 2) to reduce CAH payments from 101 percent of reasonable costs to 100 percent of reasonable costs.

HHS does not expect any significant adverse impact on rural access to care as a result of these proposals. These proposals represent targeted reductions to CAHs that have been crafted with the needs of rural areas in mind. Specifically, these proposals ensure that the basic cost-based reimbursement structure for CAHs is preserved, and that only hospitals that are the sole source of emergency and basic inpatient care for their communities maintain CAH status.

Reducing the payment rate from 101 percent to 100 percent will continue to ensure that CAH payments reflect their actual costs. Limiting CAH designation to hospitals more than ten miles from the nearest hospital will ensure that only hospitals whose communities depend upon them for emergency and basic inpatient care receive cost-based reimbursement. In fact, most CAHs are already required to be 35 miles from the nearest hospital. This proposal addresses the limited number of CAHs that still qualify under rules that, before 2006, allowed States to waive the distance requirement.

Payment Disparity

I am concerned that the disparity in payments between ASCs and outpatient hospitals may be resulting in closure of some ASCs and the movement of its physicians to hospital-based

practice, or acquisition of the ASC by the hospital. Incorporating stand-alone ASCs into a hospital system allows for the hospital to bill for services performed by an ASC facility at the Medicare outpatient services rate, which is significantly higher than the payment rate for stand-alone ASCs. Please instruct CMS to provide an estimate of the full costs of these conversions. Factors to report should include:

30. Within this group of identified physicians, calculating the 'episode' price for those physician's claims to include the facility and professional fees for the services provided in the ASC prior to closure.

In the year after the closure, evaluating whether the proportion of the same group of physicians surgical claims billed in the lower cost ASC setting for the same types of services had changed.

For physicians whose site of service includes a substantially lower proportion of ASC-based services, calculating a new 'episode' price for the surgical procedures previously performed in an ASC.

Aggregating the results of the analysis for all terminated ASCs to estimate the fiscal impact on the Medicare program of ASC closures.

Answer: CMS does not collect the type of data that would allow it to identify ASC "conversions" to provider-based outpatient departments (OPDs), which are off-campus facilities created or acquired by hospitals, versus disenrollment of ASCs from Medicare for various other reasons. Thus, we cannot calculate estimates of the cost of "conversions" you request.

We note that there is a history of growth in the overall number of Medicare-certified ASCs; in its March 2012 Report to Congress MedPAC documented a 22 percent increase in the number of Medicare-certified ASCs from 2005 through 2010.⁴ MedPAC has also noted that ASCs are less likely than hospital outpatient departments "to serve medically complex patients, Medicaid patients, African Americans, and Medicare beneficiaries who are older or eligible for Medicare because of disability".

In order to become a provider-based outpatient department, a hospital must comply with the provider-based regulations specified at 42 CFR Section 413.65. Due to ownership and location requirements, not all ASC facilities could qualify for such a conversion. Although Medicare payment for ASC services is generally lower than payment for comparable services furnished in a provider-based department of a hospital, we note that Medicare payment rates have long recognized that hospitals and hospital-based facilities generally incur greater overhead costs, and that hospitals must comply with additional programmatic obligations with respect to their provider-based departments, compared to ASCs or physician offices. Furthermore, a provider-based outpatient department may provide a wide array of service options (including emergency and specialty services) that would not be available in an ASC.

⁴http://medpac.gov/documents/Mar12_EntireReport.pdf

The Honorable Chuck GrassleyHome Health

The President's budget proposes a new copayment for home health services for new beneficiaries starting in 2017. The new copayment would be set at \$100 per home health episode and would apply for episodes with five or more visits that are not preceded by a hospital or inpatient post-acute care stay. Much of the cost of this new copayment will be passed through to Medicare supplemental policies for those who can afford them and will result in higher premiums for those policies.

For low income beneficiaries states often do not cover these out of pocket costs. And beneficiaries who do not even qualify for additional assistance and cannot afford a supplemental policy are left to cover this additional cost out of their own pockets. In addition, this additional copayment will discourage beneficiaries from using home health care when that is the more cost effective and desired site of care.

Furthermore, adding copays does nothing to fight fraud, waste and abuse in the system. But there are proposals under consideration that would use targeted home health payment reforms to end some of the schemes that fraudsters use to bilk taxpayers out of billions of dollars. These proposals would restructure low utilization payment adjustments and add episode limits to cut out the spending on these loopholes on the system and potentially save the taxpayers billions of dollars.

1. Isn't this proposal to impose home health copayments focused on the wrong place by punishing beneficiaries instead of working to cut out the abuse of the system with smart and targeted payment reforms?

Answer: The Department continues to pursue a variety of initiatives to detect and prevent fraud, waste and abuse in all our programs, including the Medicare home health benefit. However, home health services represent one of the few areas in a fee-for-service Medicare that does not currently include some beneficiary cost-sharing and adding cost-sharing will engage beneficiaries in assessing the value of these services to them. According to MedPAC research, a \$100 copayment would equate to less than \$9 per home health visit for the average episode in 2008, less than the beneficiary cost-sharing for a typical outpatient management or therapy visit.

Negative Pressure Wound Therapy

Negative Pressure Wound Therapy is an important treatment to aid the recovery of our troops and of severely injured civilians who have chronic and complex wounds. CMS has issued an RFP to suppliers of this therapy, but the RFP has no requirement that suppliers be certified as "competent" to assist patients when using the therapy at home. Nineteen clinical organizations have endorsed a set of accreditation standards to assess the competency of suppliers who bid on this work.

More importantly, CMS' position that such standards are not necessary is at odds with the position taken by the FDA. Independent physicians I have talked to agree that such standards are crucial. Having competent, trained and accredited personnel to help patients

apply the treatment at home not only leads to better patient care, but it saves the government money by reducing the amount of costly infections and misapplications that result in significant hospitalization.

2. What is the justification for not requiring suppliers to be certified to assist patients when using the therapy?

Answer: In order to furnish negative pressure wound therapy (NPWT) items and services to Medicare beneficiaries, a supplier must be accredited specifically for NPWT items and services, and must meet State licensure requirements and Medicare supplier standards. All suppliers must also meet rigorous quality standards, including the following requirements: an extensive patient assessment must be performed by competent and experienced personnel; the supplier must be available 24 hours a day to answer the patient's or caregiver's non-emergent questions, issues, or concerns regarding the NPWT equipment; the supplier must educate beneficiaries and caregivers on the safe use of equipment, including infection control practices and identifying potential hazards; the supplier is required to identify, report, and investigate any incident, injury, or infection, and identify whether changes in their programs are needed; and the supplier must only provide items that meet applicable Food and Drug Administration laws and regulations, and medical device effectiveness and safety standards

These requirements apply to all Medicare NPWT suppliers, including those who participate in the competitive bidding program. CMS will be extremely diligent in screening suppliers who bid for the NPWT product category during Round 2 of the program, to ensure that a sufficient number of qualified, accredited NPWT suppliers are available in each of the competitive bidding areas. We can assure you that contracts will only be awarded to suppliers that meet the Medicare quality standards and that are accredited specifically for furnishing covered NPWT items and services.

Section 1940

In 2007 Congress passed Section 1940 to the Social Security Act and required states to implement asset verification through an electronic system for the ABD population. Section 1940 was intended to save the taxpayer significant amounts of money. I, like many of my colleagues, am concerned continued fraud such as this in government programs is costing us dearly. Electronic asset verification allows states the ability to quickly approve services for those who are eligible and to quickly determine and deny those who are not for the sake of program integrity.

3. States were directed to roll this out in waves - a few states each year. What efforts is your agency making to enforce this law and how many of the 26 states that should already be up and running with asset verification currently have a functioning program in place?

Answer: As you know, the statute provided for a phased in implementation timeframe running from FY 2009 through FY 2013, with percentage goals for the number of aged, blind, and disabled (ABDs) Medicaid population whose assets were to be verified for each fiscal year. To implement the percentage goals phase-in requirement, States were assigned to each fiscal year using a random selection process.

All States that were required to submit State plan amendments putting their plans for complying with the AVS requirement have done so and all but one has received approval. However, to date no State has formally implemented an asset verification system for purposes of confirming eligibility for its Medicaid beneficiaries. The main reason that States have not followed through on implementation is budgetary constraints. Several States have asked CMS to waive or otherwise delay the statutory requirement that all States implement an AVS program.

Under the statute, States that have demonstrated their good faith efforts to comply with AVS requirements can submit corrective action plans for Secretarial approval. Given the fact that the vast majority of States are engaged in an effort to modernize their eligibility systems, we are working with States to use the opportunity to incorporate the elements of AVS into their systems builds. CMS will be working closely with the States to ensure that the elements needed to comply with this requirement are included in the appropriate systems development documents.

The Honorable Orrin Hatch**Medicare Imaging Services**

Latest Medicare claims data, shows a steady decline in imaging spending since 2006 (13.2 percent) while spending for non-imaging services grew by 20 percent in that same period. Also, the volume of imaging services per-beneficiary fell in 2010 as well—by 2.5 percent, according to MedPAC's latest reports.

1. Was this latest MEDPAC data considered by the Administration as it proposes further cuts to advanced imaging reimbursement in Medicare?

Answer: While MedPAC reported slight decreases in certain imaging services in 2010, utilization has still increased significantly over the last decade. This same MedPAC report found cumulative growth in the volume of imaging from 2000 to 2009 totaled 85 percent, and that, by contrast, the 2.5 percent decrease in imaging volume in 2010 was 1/30th of the cumulative increase that occurred in the previous decade. Furthermore, MedPAC evidence indicates the recent change in volume for some imaging services is likely due to concerns about radiation exposure or other general practice pattern changes. The Administration's proposal in the FY 2013 Budget Request would ensure more appropriate payment for certain imaging services by more accurately account for the amount of time that advanced imaging equipment is used.

Prior Authorization

The President's budget includes a proposal to add a prior authorization requirement to the Medicare program for advanced imaging services. This would require that Medicare patients get approval before they can get an advanced imaging test their doctor orders.

2. Presumably, Medicare would contract with radiology benefit managers (RBMs) to implement this policy. Considering, the Administration does not attribute any savings to this provision, would this provision simply end up being simply another administrative barriers?

Answer: While we do expect that the enactment of this legislative proposal would slow down the growth in the number and intensity of imaging services, at this time it is not possible to accurately estimate the magnitude of savings to Medicare. If this proposal were enacted, we would carefully examine the utilization patterns of high-cost imaging services and create a prior authorization program that aims to reduce unwarranted use of these services and protect beneficiaries from unnecessary exposure to radiation without unnecessary burden.

Further, if HHS were to develop a prior authorization program, we would seek public comment on ways to limit the administrative burden on physicians and to ensure that beneficiaries continue to have timely access to necessary medical services. Many private plans and State Medicaid agencies have been using prior authorization programs for several years to control the growth of advanced imaging services and improve the appropriate use of these studies; these examples could provide a valuable guide to structuring a prior authorization program for Medicare.

TANF Program

The 5-year authorization of the Temporary Assistance for Needy Families (TANF) programs included in the 2005 Deficit Reduction Act concluded at the end of FY 2010. For the third year in a row, the Administration has failed to propose a subsequent 5-year reauthorization of TANF. Last year, in response to my question regarding the lack of five year reauthorization proposal, you wrote that, “The Administration would be interested in exploring with Congress a variety of strategies to strength the program’s ability to improve outcomes for families and children, including helping more parents succeed as workers by building on the recent successes with subsidized employment; using performance indicators to drive program improvement; and establishing a funding structure to respond more effectively in the event of a future economic downturn.”

3. Can you elaborate on the specific policies you would support that could accomplish the stated goals particularly those that would improve outcomes for families and children and use performance indicators to drive program improvement?

Answer: When Congress takes up reauthorization, the Administration will work with lawmakers to strengthen the program’s effectiveness in accomplishing its goals. For example, we believe the Contingency Fund could be made more responsive to economic conditions, while maintaining a focus on employment. Lessons learned from the Emergency Fund could be useful in making the Contingency Fund more responsive during economic downturns. The Emergency Fund reimbursed States 80 percent of the increase in spending in three program areas compared to a base period; this model worked particularly well for employment-focused activities, such as subsidized employment. This provided important economic support, while focusing on self-sufficiency, at a time when unemployment was high and new jobs were scarce.

The Administration believes that performance indicators could be used to drive program improvement in TANF, and wants to work with Congress to identify appropriate indicators. Currently, the principal indicator of program performance in TANF is the participation rate, i.e., the percentage of families with a work eligible individual subject to work requirements engaged in one or more of a listed set of activities for a specified average number of hours per week in a month. While engagement in work-related activities is an essential aspect of moving toward employment, the current TANF structure does not measure or reward a program’s success in accomplishing key outcomes, such as whether individuals get jobs, maintain employment, or make progress in the labor force. A stronger focus on program outcomes could lead to improved program performance.

The Claims Resolution Act of 2010 required States to collect additional data on work participation and reasons for nonparticipation. The resulting reports revealed that State engagement in various work-related activities was broader than revealed by existing reporting requirements, which were primarily limited to participation in “countable activities.” It also showed that many nonparticipants had valid reasons for not participating in TANF’s work activities.

The Administration also wants to work with Congress in reauthorization to ensure that States have the flexibility to engage recipients in the most effective activities to promote success in the workforce, including families with serious barriers to employment. In our discussions with State agencies, we have repeatedly heard concerns from States that restrictions on which activities can count toward Federal participation rates and the lengths of times that activities can count can constrain State flexibility in structuring the most effective approaches to helping individuals enter employment.

4. Please describe how states are coping with years of uncertainty and potential interruption of the TANF programs.

Answer: Although the unemployment rate is declining, it remains high and the need for TANF assistance is great. Nevertheless, a number of States have made deep cuts and/or restrictions in their TANF assistance programs. For example, in 2011, at least five States have reduced their basic assistance grant levels, including California (8 percent), New Mexico (15 percent), South Carolina (20 percent), Washington (15 percent), and Wisconsin (\$20 per family). Some States have restricted benefits by shortening or otherwise tightening time limits, while other States have scaled back benefits designed to encourage work, such as TANF-funded refundable tax credits, supplemental payments for working families, or employment-related support services such as child care assistance. According to the Center on Budget and Policy Priorities, these cuts have affected 700,000 low-income families, or over one-third of TANF assistance cases. In most cases, these cuts were not to promote a policy objective, but to address State fiscal pressures.

With the expiration of Supplemental Grants and the TANF Emergency Contingency Fund, States are now receiving the same level of funding that they received in 1996. Since this amount has not been adjusted for inflation, it is only 72 percent of the value of the original block grant amount. Some States still have unspent TANF reserves and could rely on those to help tide them over, while other States may cut back on benefits and services to needy families. The Emergency Fund provided important relief for States during FY 2009 and FY 2010. However, this added funding is no longer available. Moreover, the 17 States that had relied on the \$319 million in Supplemental Grants no longer have this funding source, and the regular Contingency Fund was depleted in just six months in FY 2012, with 21 States losing over \$100 million in monthly payments effective April 2012.

TANF Contingency Fund

The President's budget would divert millions of dollars from the TANF Contingency Fund in order to make payments for the Supplemental Grant Program. The formula for distributing these grants was developed in the mid-1990s under considerably different population and economic circumstance that exist nearly 20 years later.

5. Please provide a justification for continuing to send scarce federal resources out to states based on a nearly 20-year-old formula.

Answer: The framework for Supplemental Grants was created as part of the enactment of the original 1996 law, based on concerns from a set of States about the equities of providing block grant amounts that simply reflected the amount of money that States had been receiving from the

prior programs in the early 1990s, without regard to population growth or State spending per poor individual. While the block grant structure itself is largely based on providing States with the same funding levels they received in the early to mid 1990s, the Supplemental Grants were established because Congress determined that a set of States were disadvantaged by that formula and should be provided supplemental funds to address that disadvantage.

Child Care

Secretary Sebelius, one of the challenges in determining an appropriate level of child care spending has been the difficulty in quantifying what an increase in child care funding means in terms of increasing actual child care slots.

The Administration's budget for FY 2012 included \$500 million in increased mandatory funding and \$800 million in increased discretionary funding for child care resulting in a total of \$6.3 billion in Child Care and Development Funds and made the claim that increasing those child care funds would enable 220,000 more children to receive child care.

In the FY 2013 Budget, the Administration includes \$500 million in increased mandatory funding and \$325 million in discretionary spending resulting in a total of \$6 billion in Child Care and Development Funds and makes the claim that these funds will enable 70,000 more children to receive child care funds.

6. Please explain how a reduction of \$300 million translates into a projected loss of service to 150,000 children.

Answer: Although the total increase in the FY 2013 Budget is \$825 million, the Administration proposes to allocate \$300 million to for a Child Care Quality Improvement Initiative. This new initiative will challenge all States to fund providers improve their quality and enhance consumer education efforts to help parents select the best quality child care to meet their families' needs. Funds will be distributed to each State so that all States have the opportunity to implement quality reforms, and States with the most ambitious proposals will be eligible for additional funds.

A number of different factors drive the child care caseload such that the number of children that can be served with a given funding level varies from year to year. These factors include the estimated average annual subsidy per child spending rates, assumptions about the amounts of TANF funds transferred into CCDF, State matching requirements, and assumptions about the percentage of funds spent on direct services using historical data and trends.

The chart below provides a comparison of the FYs 2012 and 2013 Budget proposals.

CCDF	PB 2012	PB 2013	
Mandatory	+\$500 million	+\$500 million	
Discretionary	+\$800 million	+\$325 million	
<i>Increase Over Baseline</i>	<i>+\$1.3 billion</i>	<i>+\$825 million</i>	<i>(\$300m for quality)</i>
<i>Add'l Children Served</i>	<i>+\$1.3 billion = +220,000</i>	<i>+\$525 million = +70,000</i>	

Funding Request Level	\$6.3 billion	\$6 billion
Baseline	\$5 billion	\$5.2 billion
Difference in the amount of the increases requested: (\$1.3 billion) – (\$525 million) = \$775 million		

Safe and Stable Families Program

Last year, the Congress passed and the President signed P.L. 112-34, which reauthorized the Promoting Safe and Stable Families Program. Included in this bipartisan legislation was a provision allowing the Secretary to extend certain grants to regional partnerships to improve outcomes for children affected by parental substance abuse.

7. Please report on the process underway to distribute those grants in a manner consistent with Congressional intent.

Answer: The regional partnership grant authority is a useful tool in the overall effort to address caregiver substance use and child well-being. The provision allowing the Secretary to extend previous grants is important and we are working to reconcile the new statutory authority with our grants administration requirements.

Medicaid

Under the FY2013 Budget, Washington's spending on the Medicaid program will grow by more than 30 percent as a share of our country's gross domestic product and by more than 50 percent in terms of actual dollar amounts. As you know, both the federal government and the states fund the Medicaid program – so these estimates do not even include the new burdens an expanding Medicaid program will place on the states.

8. Do you have an estimate of the state share of spending on the Medicaid program over the next 10 years? If not, please have this analysis done by OACT or OMB, as appropriate, and share the results with the Finance Committee by March 31st.

Answer: Estimates from OACT are provided below.

**FY 2013 President's Budget
Medicaid State Expenditures**

Projected Expenditures in Billions of Dollars

	Total
2013	204.4
2014	215.9
2015	229.9
2016	246.5
2017	265.1
2018	282.5
2019	301.9

2020	326.6
2021	352
2022	375.8
5-Year	1,161.80
10-Year	2,800.60

Secretary Sebelius, according to an analysis of Medicaid Statistical Information System (MSIS) data on benefit spending and the CMS-64 data reported by states for the purposes of reimbursement, there is approximately \$45 billion a year in Medicaid spending that cannot be tracked directly to actual services for specific patients. It is my understanding that the MSIS and CMS-64 databases are not reconciled on a routine basis to account for that gap.

9. What is HHS doing to resolve this problem with program management? And when will it be completed?

Answer: The new Medicaid Statistical Information System (MSIS) - now called T-MSIS – is a subset of data fields in the Medicaid Management Information System (MMIS). T-MSIS will enable service utilization and financial information in the State MMIS to be accurately summarized and enable States to utilize T-MSIS payment data to claim Federal matching funds through the Form CMS-64 expenditure report.

However, as you note, there are State Medicaid expenditures reported on the Form CMS-64 which are payments made outside of the MMIS. These expenditures are not claim-specific (e.g., administrative costs, Medicare premium payments on behalf of Medicare-Medicaid enrollees, Disproportionate Share Hospital (DSH) payments, supplemental payments, and certain section 1115 demonstration expenditures). While these expenditures are currently made outside of the MMIS, we are working with States to accurately report such expenditures in T-MSIS, which will help eliminate the reporting differences between the two systems.

Secretary Sebelius, under current law, HHS is required to annually report to Congress on the financial status of, enrollment in, and spending trends for the Medicaid program. This report was released for 2010, but HHS missed the deadline for 2011 by nearly 2 months. The information in this report is critical for Congress – and the American people – to know in order to make prudent decisions about this health care entitlement.

10 . Why did HHS miss this deadline? And when can we anticipate the report be delivered to Congress as required under current law?

Answer: Please be assured that I share your interest in protecting the long-term financial health of the Medicaid program. The annual actuarial report on the financial outlook of the Medicaid program provides an analysis of past and projected national trends in Medicaid enrollment and expenditures.

Our Department has worked diligently on the report, and I anticipate that it will be released very soon.

On January 27, 2012, CMS finally issued a proposed rule to implement the Medicaid drug policy provisions of the Patient Protection and Affordable Care Act, including guidance on the calculation of the Average Manufacturers Price and the Federal Upper Limit (FUL). Stakeholders are expected to comply with the FULs related to the calculation of AMP, but until this proposed rule is final manufacturers, pharmacists, and states have been and are still forced to guess the intent of CMS when it comes to performing tens of billions of dollars in calculations. I am concerned that this lack of clarity continues to pile unnecessary burdens and confusion on health care providers who are already struggling during tough economic times.

11. By what specific date will CMS finalize the proposed rule?

Answer: CMS is working to pursue a transparent rulemaking process. Our Medicaid covered outpatient drug rule allows for a 60-day comment period through April 2, 2012. CMS will carefully review all comments that come in and will respond to them in the final rule, which we plan to issue in 2013.

Center for Medicare and Medicaid Integration

I appreciate the attention that the Center for Medicare and Medicaid Integration has paid to increasing quality and lowering costs for the dually eligible population. As Congress evaluates policies for how to better care for these beneficiaries, it would be helpful for CMS to share detailed information on the experiences and results of the demonstration programs currently being implemented. In that spirit, I have a number of questions about these demonstration programs:

12. What is CMS' goal as far of the scope of these demonstrations? Does CMS plan to limit the size of the demonstrations until sufficient data is available to evaluate them?

Answer: CMS evaluates the designs submitted by States for demonstration projects on an individual basis subject to a cap of 2 million Medicare-Medicaid enrollees. Once States are selected for the implementation phase, a contractor rigorously evaluates the demonstrations for quality and cost impacts. Throughout the process, CMS will monitor State performance closely to ensure proper compliance with demonstration guidelines and cost. This approach will ensure that the funds invested provide valuable results.

13. What will be the process moving forward to evaluate these demonstrations? How much staff does CMS plan to allocate for this purpose? Please outline the specific data, analytics, and timeline with which CMS plans to evaluate these demonstration programs.

Answer: An evaluation of the model's performance is planned for each model tested by the Innovation Center. The evaluation is intended to determine whether a model leads to spending

reductions, improvements in the quality of care delivered, and/or better patient health outcomes and experiences. All participating States will be required to work with an independent evaluator to track and provide agreed-upon data as needed for the evaluation. As applicable, these data will be merged with administrative claims data collected by CMS to allow assessment of performance on topics such as clinical quality performance, patient functional status, and financial outcomes. The Innovation Center anticipates using multiple cycles of data collection due to the changing nature of the approaches used by participants in response to rapid-cycle feedback. Particular care will be taken to identify the effect of each reform in the context of other interventions.

Once the models have been in the testing phase long enough to generate sufficient data, the CMS Office of the Actuary will review the data as part of the determination of whether a modification, termination, or expansion of the model is warranted. To date, none of the Innovation Center models have been in the testing phase long enough to generate sufficient data for the Actuary to make such a determination.

The Center for Medicare and Medicaid Innovation is currently testing the following models specifically related to care for Medicare-Medicaid enrollees (also referred to as “dual eligibles”):

- **State Demonstrations to Integrate Care for Dual Eligible Individuals¹:** Upon thorough evaluation by a technical review panel, 15 States were selected to receive up to \$1 million to support the design of programs to better coordinate care for Medicare-Medicaid enrollees. The twelve-month design period began April or May 2011, depending on the State’s contract execution date. The primary deliverable of the design contract will be a detailed demonstration model describing how each State would structure and implement its proposed integrated program. States are required to engage in significant work with their stakeholder community during the design phase to ensure broad and ongoing stakeholder input on their implementation proposal. All final proposals will undergo thorough Federal review; CMS will work with States to implement the plans that hold the most promise.

Each of the 15 selected States has provided a description of its initial proposal to CMS. The selected States are in different stages of development and will use the design contract period to further develop their approaches.

- **Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees:** A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS will test two models, a capitated and a managed fee-for-service model, for States to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees.

¹ More information is available at: http://www.cms.gov/medicare-medicare-coordination/05_StateDesignContractSummaries.asp#TopOfPage.

Thirty-eight States and the District of Columbia have submitted non-binding Letters of Intent (LOIs) to participate in the demonstration. CMS has established lines of communication with all States that submitted LOIs. For those States that determine they would like to pursue a demonstration, the LOI and initial dialogue with CMS have launched a comprehensive planning and design process. States are required to work with stakeholders during the design process and during implementation (for those States that ultimately implement).

The design process will culminate in a State demonstration proposal to CMS. Upon submission (following a 30-day public notice period), CMS will evaluate each proposal as to whether it has met or exceeded the CMS established standards and conditions before the State can enter into a formal Memorandum of Understanding (MOU) with CMS. Once a proposal has met the standards and conditions, CMS will work with States to develop a MOU based on the draft templates provided as part of the July 8, 2011 State Medicaid Director's letter.² Following the MOU, States pursuing the capitated model would undergo a process with CMS to select qualified health plans that would result in a 3-way contract among CMS, the State, and plans.

The last step for the Managed fee-for-service model is the execution of a final agreement between CMS and the State. The State demonstration proposal must demonstrate that it has the reasonable ability to meet the following planning and implementation milestones prior to the expected implementation date:

- Meaningful stakeholder engagement
 - Submission and approval of any necessary Medicaid waiver applications and/or State plan amendments
 - Receipt of any necessary State legislative or budget authority
 - Joint procurement process (for capitated models only)
 - Beneficiary outreach/notification of enrollment processes, etc.
- **Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents:** This initiative aims to reduce costly and potentially dangerous avoidable hospitalizations by providing enhanced on-site services and supports in the nursing facility. To improve quality and reduce costs, CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to long-stay residents of nursing facilities. Applications are due June 14, 2012.

14. How will CMS evaluate a demonstration's progress where there is no control group of beneficiaries?

Answer: Other evaluation methodologies can produce definitive results. The evaluation design for each demonstration will be determined based on the particular characteristics of the demonstration, the settings in which it is implemented, and the effects to be measured. CMS

² State Medicaid Letter is available here:
https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

demonstrations typically entail changed or enhanced services or program features. The effects of such changes are evaluated by comparing outcomes for the group receiving the new program model with outcomes for those not affected by such intervention. This may be a control group, in a randomized design, or, in a quasi-experimental design, a carefully selected comparison group not affected by the program but comparable in other respects. All demonstrations are subject to comprehensive and rigorous independent evaluations, which will closely inform any decisions about future expansion. Once the models have been in the testing phase long enough to generate sufficient data, the CMS Office of the Actuary will review the data as part of the determination of whether a modification, termination, or expansion of the model is warranted. To date, none of the Innovation Center models have been in the testing phase long enough to generate sufficient data for the Actuary to make such a determination.

Duals and Part D

For the approximately 2 million dual eligibles which may be enrolled in demonstrations, I am interested to learn about the implications for Medicare Part D. As you know, dually eligible beneficiaries are auto-assigned into a Part D plan that bids below the average bid, and many plans bid below the average primarily to serve these beneficiaries.

15. If dually eligible beneficiaries participating in demonstrations are no longer enrolled into low-bidding plans, I am interested to learn how this would impact plan incentives to bid low in Part D. What analysis has HHS conducted to evaluate these incentives?

Answer: It is too early to tell whether the participation of Medicare-Medicaid enrollees (also known as “dual eligibles”) in demonstration plans will have any effect on Part D plan sponsors’ incentive to bid below the regional benchmark in order to qualify for auto-assignment of dual eligible beneficiaries. Nevertheless, CMS will monitor for this effect as the demonstration progresses.

There are a number of countervailing factors that may mitigate this concern. First, at this time we do not know how many Medicare-Medicaid enrollees will ultimately be enrolled in demonstration plans. Second, in States where demonstration plans go into effect, Part D plans will still have strong incentives to bid low in order to offer competitive premiums to the majority of Medicare beneficiaries who do not receive the low-income subsidy (LIS). Low-bidding plans will also be able to receive auto-assignment of LIS beneficiaries who are not full dual eligible beneficiaries (those who applied for LIS through the Social Security Administration and those deemed into LIS through enrollment in Medicare Savings Programs) if the plan bid is below the regional benchmark for the low-income premium subsidy amount. Plans with bids below the benchmarks will also be able to offer zero-premium Part D coverage to full dual eligible beneficiaries who opt out or are otherwise excluded from the demonstration. Finally, dual eligible beneficiaries enrolled in demonstration plans may have complex health care needs, including higher than average prescription drug costs. In this case, total Medicare program costs could be lowered when the demonstration plans assume their responsibility to better manage these beneficiaries’ care and improve quality.

Health Insurance Reform Implementation Fund

Section 1005 of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively PPACA) appropriated \$1 billion to the

newly established Health Insurance Reform Implementation Fund (Fund) for implementation expenses related to PPACA.

16. Please provide a detailed breakdown of how this money has been spent thus far including how much has been spent for administrative expenses (such as salaries, benefits and contracts), operations, communications (including advertisements, education or other efforts relating to communicate the effects of PPACA), and any other aspect of PPACA for which money from this fund has been expended.

Answer: The below table displays the spending from the Health Insurance Reform Implementation Fund as of February 29th, 2012, by agency:

Organization	Obligations	Outlays
Internal Revenue Service	\$213,264,945	\$154,181,697
Office of Personnel Management	2,938,850	1,442,102
Department of Labor	3,055,102	2,958,880
Department of Health and Human Services	251,742,492	134,917,483
Total Health Reform Implementation Fund	\$471,001,389	\$293,500,162

HHS uses these funds to implement Medicare and Medicaid changes required in the ACA, including closing the Part D coverage gap and developing new value-based purchasing models for Medicare providers. HHS has also used these funds to plan and prepare for the establishment of state - based and Federally-facilitated Exchanges as required in the ACA.

The Office of Personnel Management (OPM) uses funding to plan for implementing and overseeing the establishment of at least two Multi-State Plan Options to be offered on each state health insurance exchange beginning in 2014, and allowing Tribes and Tribal organizations to purchase Federal health and life insurance for their employees.

The Department of Treasury uses funding to implement multiple tax changes from the Affordable Care Act, including the Small Business Tax Credit, expanded adoption credit, excise tax on indoor tanning services, charitable hospital requirements, plan for Exchanges, and a number of other revenue provisions.

The Department of Labor uses funds to conduct compliance assistance; modify or develop IT systems that support data collection, reporting, policy and research; and develop infrastructure for the newly required Multiple Entity Welfare Arrangements reporting and registration within the Affordable Care Act.

Of the \$251,742,492 obligated by HHS to date, approximately 13% has paid for personnel, 84% has supported contractual services, and 3% has been obligated for rent, supplies, or other miscellaneous services.

Health Professional Shortages

As you know, there are serious national health professional shortages in many pediatric specialties, shortages which the Children's Hospitals Graduate Medical Education (CHGME) program has been crucial in helping to address. The children's hospitals in the CHGME program train 51% of all pediatric specialties. In some specialties, like pediatric urology, the CHGME hospitals train almost 100% of those providers. Significant reductions to the program would exacerbate these shortages and create additional barriers to access to specialty care for children.

17. What analysis did you conduct and what result led you to determine a 66% reduction in budget authority for the program?

Answer: The Children's GME Payment Program relies on many of the regulations for Medicare GME, and accordingly, makes payments comprised of two components – one to support direct costs (1/3 of the total payment) and one indirect costs (2/3 of the total payment). Indirect Medical Education (IME) costs are not well documented and have been the subject of some debate.³ As a result, in difficult budgetary times when we must maximize every taxpayer dollar, the FY 2013 President's Budget prioritizes funding for the direct medical education (DME) portion of the CHGME payment, providing for the training of residents in freestanding children's hospitals. These DME payments support the costs of resident salaries, expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, costs associated with providing the GME training program, and allocated institutional overhead costs.

Medicare Integrity Program

In the Budget document released to Congress, the Administration estimated a 14:1 return on investment (ROI) for Medicare Integrity Program (MIP) activities. However, on July 29, 2011, the Government Accountability Office (GAO) published a report titled, "Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness, GAO-11-592" that recommends that CMS expeditiously improve the data used to calculate the ROI. Specifically, the GAO recommended that CMS:

Periodically update ROI calculations after contractor expenses have been audited to account for changes in expenditure data reported to CMS and publish a final ROI after data are complete, and

Expediently complete the implementation of data system changes that will permit CMS to capture accurate MAC spending data, thereby helping to ensure an accurate ROI.

³ Medicare Payment Advisory Commission, June 2010, Chapter 4: Graduate medical education financing: Focusing on educational priorities, MedPAC Report to Congress: Aligning Incentives in Medicare, 110-117.

To help us understand the accuracy of the MIP ROI contained in HHS' 2013 Budget Submission, please provide the following:

18. Explain whether CMS incorporated recommendations by the GAO in its July 29, 2011 report into its 2103 Budget Submission and describe whether these changes increased or decreased CMS' ROI estimates in FY 2013.

Answer: The FY 2013 Budget Submission did not incorporate the GAO recommendations, because CMS is working on evaluating our current methodology. CMS is committed to identifying improvements to the current approach for calculating the return on investment (ROI) for Medicare Integrity Program (MIP) activities. CMS is working to address GAO recommendations through the development of internal workgroups, consisting of staff from several components, to explore more efficient ways to collect MAC cost data and calculate ROI performance statistics. Changes to the collection or calculation of cost data are generally implemented during the renewal of MAC contracts. Since all MACs are not renewed during the same period, it may take time to fully implement any changes. As CMS continues to develop possible changes, it will evaluate whether to recalculate the ROI.

19. If HHS did not include GAO's recommendation into the 2013 Budget Submission, explain why and estimate the impact of these changes on the 2013 MIP ROI estimate.

Answer: CMS is committed to identifying improvements to the current approach for calculating the return on investment (ROI) for Medicare Integrity Program (MIP) activities. Changes to the collection or calculation of cost data are generally implemented during the renewal of MAC contracts. Since all MACs are not renewed during the same period, it may take time to fully implement any changes. . However, CMS has established internal workgroups, consisting of staff from several components to explore more efficient ways to collect MAC cost data and calculate ROI performance statistics. As CMS continues to develop possible changes, it will evaluate whether to recalculate the ROI.

20. Explain whether CMS independently audits the MIP ROI furnished to Congress.

Answer: CMS reviews all data used to calculate the MIP ROI and is continuously looking for opportunities to improve the MIP ROI calculation.

Based on a 2009 fact sheet (available at <https://www.cms.gov/OrgMedFFSAppeals>), providers are successful in overturning approximately 53 percent of Part A determinations during the first two levels of appeal (redetermination and reconsideration). Moreover, suppliers are successful in overturning approximately 65 percent of Part B determinations during the first two levels of appeal.

21. Accordingly, explain whether MIP ROI shown in the 2013 Congressional Justifications contain the unadjusted rate (before factoring in appeals) of return or

the adjusted rate of return (after factoring in appeal reversals) for each activity shown.

Answer: The MIP ROI contained in the 2013 Congressional Justification is a historical rate of actual savings/recoveries that take into account appeal reversals. Appeal reversals are factored into the savings in the year in which the adjustment is made; therefore, there would be no retroactive change to original savings figures.

22. Explain whether the adjusted rate of return for the program integrity ROI is similar as the as that used in calculating the improper payment amount for the original Medicare program in 2011. Describe the differences in the adjusted rate of return used by CMS for medical review, audit, and Medicare secondary payer.

Answer: CMS uses a different methodology to calculate MIP activities' ROI and the Medicare fee-for-service error rate (also referred to as the Comprehensive Error Rate Testing, or CERT). Savings from MIP activities are based on actual pre- and post-payment claim denials, whereas CERT is an extrapolation of improper payments based on a statistically-valid sample of claims reviewed by our contractors.

Regarding the differences in the adjusted rate of return for medical review, overturned appeals are included in the medical review savings report in the year the claim was overturned. For example, if a claim is denied in 2010 and the denial is overturned on appeal in 2012, the overturned appeal is reported against the medical review savings in 2012. This same methodology applies to the Medicare Secondary Payer program. However, cost report audit savings are not reduced by appeal reversals since the appeals frequently do not relate to items denied on audit. Providers often appeal CMS policy interpretations by appealing cost reports.

23. Provide the actual cost, savings, MIP ROIs for each line item in the FY 2009, FY 2010, FY 2011 MIP appropriation. In addition, please describe if any savings are net of any claims reversed on appeal.

Answer: CMS is currently reviewing the availability of this information and will follow up with the Senator's staff regarding this request.

24. Explain whether CMS will begin to calculate a State-based Medicaid and/or Children's Health Insurance Program (CHIP) ROI.

Answer: CMS does not plan to calculate a State-based Medicaid and/or CHIP ROI on a state-by-state basis at this time. However, we are aware that States calculate their program ROIs. Although we do not collect a discrete ROI ratio from States through the annual State Program Integrity Assessment, we do collect information about common components of ROI calculations (e.g., recoveries and estimated cost avoidance). Recently, a few States have requested assistance in calculating ROI. Accordingly, we have scheduled a 'working' meeting at the next meeting of the Medicaid Integrity Institute. The goal of the meeting will be to develop recommendations for a model strategy to calculate ROI for State program integrity activities.

Medicare Contractor Provider Satisfaction Survey

The 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) shows a high level of dissatisfaction with Medicare' fee-for-service contractors in the areas of provider enrollment (28%), provider inquiries (17.8%), medical review (17.4%), and appeals (17.3%). In addition, based on based on table VI.1, (page 21) providers and suppliers cite inconsistent responses or decisions as a major problem.

25. Please describe CMS efforts to correct these deficiencies and ensure that providers and suppliers receive timely and accurate information.

Answer: CMS' number one goal is to ensure our Medicare beneficiaries receive the right services, at the right time, in appropriate levels of care, and at the right price. While CMS has made progress in reducing improper payments, we acknowledge that more work remains. The processes you listed above – provider enrollment, provider inquiries, medical review, and appeals -- are a vital part of our efforts to reduce improper payments. Most improper payments occur because a provider or supplier does not comply with Medicare's coverage, coding, or billing rules. CMS and its contractors ensure providers comply with the rules and supply required documentation by performing medical reviews. Our contractors strive to give timely, consistent, and accurate information to providers.

CMS provides national educational information on policy and/or documentation requirements to Medicare fee-for-service providers and suppliers through the Medicare Learning Network. In addition, individual contractors issue their own articles to explain their regional coverage policies. Contractors host webinars, advisory forums, one-on-one educational sessions, on-site meetings, and in-person visits, as well as work closely with CMS Regional Offices to communicate CMS policy and documentation requirements for medical review.

CMS is constantly working to update, improve, and simplify our processes as much as possible in order to make these areas as easy and painless as possible for the providers and suppliers who partner with us in providing health care to beneficiaries. Below are a few options we are currently exploring that we anticipate will improve provider satisfaction:

- Encourage contractors to update the appeals process with the use of technology, so that appeal requests and supporting documentation can be submitted by providers/suppliers electronically and status updates and confirmation of appeals receipts can be managed using automated services.
- Improve the Provider Enrollment, Chain, and Ownership System so that many of the enrollment documents can be submitted online.
- Maintain and improve data analysis and quality assurance programs to assess the quality, timeliness, and consistency of responses to provider inquiries.
- Assess independently, on a monthly basis, the accuracy and consistency of responses to provider telephone inquiries.
- Perform extensive outreach and education to providers and suppliers so that claims can be submitted accurately the first time; successful outreach and education includes "Frequently Asked Questions" documents, web-based training, educational products, and national calls.

- Provide detailed Medicare Contractor Provider Satisfaction Survey (MCPSS) reports to contractors so they can implement process improvement initiatives tailored to the providers in their jurisdictions.
- Expand provider and supplier Internet portal access and functionality.
- Pilot customer service enhancements in the provider contact centers.

Medicare Consolidation

In the 2011 HHS Budget in Brief, HHS proposed consolidating medical review and provider enrollment activities within the Medicare program. This consolidation was estimated to save \$1.5 billion for medical review administrative costs for the period of 2011 – 2020 and \$140 million for provider enrollment for the period of 2011 – 2020. HHS' 2013 Budget in Brief no longer contains a proposal to consolidate provider enrollment.

28. Explain HHS' decision to forgo medical review and provider enrollment consolidation.

Answer: HHS is committed to ensuring the integrity of the providers who participate in the Medicare program and finding efficiencies in our administrative contracting functions.

While CMS supports achieving efficiencies in our contracting and the standardization that can occur as a result of using fewer contractors, we must address various system and operational challenges before we can consolidate these functions. Further, CMS has just implemented Automated Provider Screening, which replaced the time- and resource-intensive manual review process of multiple data sources by automating the checks. CMS anticipates that the new process will decrease the application processing time, while increasing the accuracy of its enrollment data.

Medicare Advantage Audits

I continue to hear concerns that CMS is not applying consistent audit standards from plan to plan within Medicare Advantage and also that CMS is not applying consistent audit standards between fee-for-service and Medicare Advantage. It is difficult for Medicare Advantage plans to be accountable when there is a black box methodology being used to evaluate them. I appreciate the fact that CMS has finally proposed draft methodology for the RADV audits and that there are audits ongoing now, but am concerned that regulations governing this process have yet to be issued.

29. When will CMS be issuing clear, transparent, and consistent standards for these RADV audits?

Answer: CMS is committed to transparency in all of our administrative activities. On December 21, 2010, CMS posted on its website the "Medicare Advantage Risk Adjustment Data Validation (RADV) Notice of Payment Error Calculation Methodology for Part C Organizations Selected for RADV Audit – Request for Comment." CMS invited 30 days of public comment on the proposed methodology, through January 21, 2011.

Since that time, CMS has been carefully reviewing the more than 500 comments received on the draft methodology and plans to release the final methodology in the coming weeks.

The Honorable John Kerry and The Honorable Chuck Grassley

1915(c) Demonstration Program

The 1915(c) demonstration program has shown great success in improving outcomes, reducing bed days, and increasing access to appropriate services for youth needing mental health treatment.

1. Since an expansion of this program was not included in the President's FY2013 budget, what do you see as next steps for building on the success of this program? We support a nation-wide expansion to allow for home and community-based services to youth who would otherwise likely require the level of care provided in a psychiatric residential treatment facility and look forward to working with you to make this happen.

Answer: CMS is very pleased with the results we have gathered so far from the "Community Alternatives to Psychiatric Residential Treatment" Demonstration, and CMS expects that the final report that is currently being drafted for this demonstration may confirm that providing community-based services to children who may otherwise require treatment in a psychiatric residential treatment facility improves outcomes for the children served and is cost-effective for both States and the Federal government. The nine State demonstrations will continue serving children until the end of the current fiscal year, and we will continue supporting participating States until then.

Beyond this current demonstration, we look forward to working with Congress to explore amending federal Medicaid law to permit all States to similarly extend community-based services to children. CMS will continue to help identify the full range of options, including waivers, available to all States interested in maximizing their community-based options for the children served by their Medicaid programs.

The Honorable John Kerry**Children's GME**

The Children's GME program was intended to correct unintentional inequities in the federal government's support for graduate medical education that left children's hospitals largely without support, since they generally do not treat patients covered by Medicare.

1. Do you feel that the CHGME program has been a success and has helped to address the inequity between Medicare GME and free standing children's hospitals?

Answer: CHGME was created to address a specific gap with respect to federal support for residency training at children's hospitals, and has been successful in doing so. In academic year 2010-2011, the CHGME payment program supported approximately 6,000 full-time equivalent (FTE) residents at 55 eligible children's hospitals in 30 states and Puerto Rico. Approximately 46 percent of supported FTE residents were training in pediatrics, 28 percent in pediatric subspecialties, and 26 percent were non-pediatric residents on rotation. In Academic Year (AY) 2010, an estimated 11,200 pediatricians and pediatric specialists received residency training.¹ It is important to note that freestanding children's hospitals are not the only entities that provide residency training to pediatricians and pediatric subspecialists.

2. If so, why would we put that success at risk by underfunding the program?

Answer: The FY 2013 Budget request of \$88,000,000 will support the direct portion of graduate medical education payments for participating institutions. In careful planning for this budget request, it is expected that programs will utilize infrastructure in place to support specific residency class size, minimizing the impact of reduction in IME.

3. Why would we propose treating CHGME differently than Medicare GME?

Answer: We are working within the context of a challenging budget environment, which requires a closer examination of how resources are spent and tough decisions regarding funding priorities. Medicare GME is a mandatory program and Children's Hospital GME Payment Program is a discretionary program. The decision to propose to fund only direct medical education was not made based on a comparison to the Medicare GME payment program, but is reflective of the challenging budget environment. Indirect medical education costs are not well documented and have been the subject of some debate in Medicare GME as well. In a time of limited federal resources, the FY 2013 President's Budget does not propose to fund these costs in the CHGME program and reduces IME in Medicare GME by 10 percent.

¹ Brotherton, Sarah and Etzel, Sylvia. September 7, 2011, Graduate Medical Education, 2010-2011, *Journal of the American Medical Association*, Vol. 306 (9), 1015 – 1018.

The Honorable Robert Menendez**Postpartum Depression and Psychosis**

As we discussed during the hearing, I included specific language into the Affordable Care Act (Sec. 2952) that directs HHS to address the critical condition of postpartum depression and postpartum psychosis (together “postpartum conditions”). In response to my question about HHS’s progress in implementing this provision, you mentioned some ongoing work at the National Institute of Mental Health.

1. Could you please identify which of those grants have been issued pursuant to the guidelines set forth under Sec. 2952(b) or how those specific goals have been incorporated into existing programs?

Answer: Congress did not appropriate funds for Affordable Care Act Section 2952(b), which authorizes grants to provide services to individuals with a postpartum condition and their families. However, HRSA is currently funding activities related to perinatal depression under the Healthy Start Program. These activities were being conducted prior to the Affordable Care Act, as perinatal depression is an important issue that impacts many of the women served by the Healthy Start program.

Specifically, all of the 105 Healthy Start projects in 39 states are required to screen for perinatal depression and refer those identified with depression for mental health services. The purpose of the Healthy Start perinatal depression screening is to prevent or reduce depression among Healthy Start participants. In addition, HRSA has developed a consumer booklet in Spanish and English titled *Depression During or Around the Time of Pregnancy*, currently the most requested publication from the HRSA Information Center. The HRSA web site includes these documents and more information for consumers on perinatal depression at: <http://mchb.hrsa.gov/pregnancyandbeyond/depression/index.html>.

In addition to the Healthy Start program activities, the Maternal and Child Health Research Program is funding two research projects related to perinatal depression.

Also, Sec. 2952(c)(2) requires that a study be conducted into the benefits of screening for postpartum conditions and reported to Congress within two years of the ACA’s enactment.

2. Since the deadline is only a few weeks away, could you please provide a detailed update on the status of this report and any significant finding it might contain?

Answer: The programs authorized by Sec. 2952(c) did not receive appropriations.

Essential Health Benefits Package

During the hearing I also mentioned the language I had included into the Affordable Care Act to ensure behavioral health benefits are included in the essential health benefits (EHB) package. I specifically included this language to ensure families struggling with autism and autism spectrum disorders can rest assured these services will be covered under a qualified health plan. As I mentioned to you during the hearing, as well as in writing in January, I have serious concerns with how the proposed benchmarking of the EHB will treat the behavioral health services requirement. A few days after the hearing CMS issued a “Frequently Asked Questions” document further explaining how the EHB benchmarking approach would work, which raises additional questions about behavioral health coverage in the EHB.

In response to question 5, the document states that “if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category.”

3. For the 21 states without mandated coverage of autism services, are there sufficient plans offering this benefit to ensure a state will be able to find a substitute benchmark?

Answer: On December 16, 2011 HHS released the Essential Health Benefits Bulletin to provide information and solicit comments on the regulatory approach that HHS intends to take in defining Essential Health Benefits. The bulletin described four types of plans that States could choose from to select their benchmark for benefit years 2014 and 2015. The bulletin also described a policy for dealing with situations where the benchmark is missing one of the ten categories of benefits described in section 1302(a) of the Affordable Care Act. We note that mental health and substance use disorder services, including behavioral health treatment, are among the 10 statutorily-required categories of benefits that must be included in every plan subject to the EHB. In general, States would be required to supplement missing categories of benefits from any other benchmark option. We welcome comments on our intended approach and anticipate that further details about essential health benefits will be forthcoming as HHS proceeds with rulemaking.

4. How would HHS and the states ensure coverage of these benefits if no such substitute benchmark exists?

Answer: As discussed in the answer to question 3 above, mental health and substance use disorder services, including behavioral health treatment, are among the 10 statutorily-required categories of benefits that must be included in every plan subject to the EHB. In general, States would be required to supplement missing categories of benefits from any other benchmark option. We welcome comments on our intended approach and anticipate that further details about essential health benefits will be forthcoming as HHS proceeds with rulemaking.

6. For the 29 states with mandated coverage of autism services, how will HHS ensure that states do not undermine the statutory intent that behavioral health services be available by imposing non-dollar limits on coverage?

Answer: Mental health and substance use disorder services, including behavioral health treatment, are among the 10 statutorily required categories of benefits that must be included in every plan subject to the EHB. The Essential Health Benefit FAQs issued on February 17, 2012, state that, in reference to States imposing limits on coverage, “plans would be permitted to make actuarially equivalent substitutions within statutory categories...[including] non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.” We welcome comments on our intended approach and anticipate that further details about essential health benefits will be forthcoming as HHS proceeds with rulemaking.

7. Where will the line be drawn at what is, and what is not, an acceptable benefit level?

Answer: On December 16, 2011 HHS released the Essential Health Benefits Bulletin to provide information and solicit comments on the regulatory approach that HHS intends to take in defining Essential Health Benefits. The bulletin described four types of plans that States could choose from to select their benchmark for benefit years 2014 and 2015. The bulletin also described a policy for dealing with situations where the benchmark is missing one of the ten categories of benefits described in section 1302(a) of the Affordable Care Act. In general, States would be required to supplement missing categories of benefits from any other benchmark option. We welcome comments on our intended approach and anticipate that further details about essential health benefits will be forthcoming as HHS proceeds with rulemaking.

8. Will HHS recognize a plan with as little as one or two behavioral health sessions a year (a far cry from the number of sessions to provide any positive outcomes), as meeting the EHB requirements?

Answer: On December 16, 2011 HHS released the Essential Health Benefits Bulletin to provide information and solicit comments on the regulatory approach that HHS intends to take in defining Essential Health Benefits. The bulletin described four types of plans that States could choose from to select their benchmark for benefit years 2014 and 2015. The bulletin also described a policy for dealing with situations where the benchmark is missing one of the ten categories of benefits described in section 1302(a) of the Affordable Care Act. In general States would be required to supplement missing categories of benefits from any other benchmark option. We welcome comments on our intended approach and anticipate that further details about essential health benefits will be forthcoming as HHS proceeds with rulemaking.

Per Capita FFS Spending in Puerto Rico

As you are aware, I have urged CMS to exercise its authority to make adjustments to the calculation methodology used to determine the per capita FFS spending rates in Puerto Rico. I appreciate the work CMS has done to refine the methodology, so that it will be based exclusively on beneficiaries who are enrolled in both Part A and Part B. However, rates in Puerto Rico are still projected to drop by over 26 percent by 2017.

9. What additional adjustments are CMS and HHS making regarding the methodology used to allow for a more accurate calculation of per capita FFS spending in Puerto Rico for the 2013 MA bidding process?

Answer: I share your concern for the unique situation in Puerto Rico with respect to Medicare Advantage (MA) payment rates. As you know, in the fall of 2010, CMS conducted a detailed analysis of Medicare fee-for-service (FFS) spending in Puerto Rico. The results of that analysis confirm that Medicare enrollment, cost, and usage patterns in Puerto Rico are different than those in the 50 States. More specifically, beneficiaries in Puerto Rico are required to opt into Part B coverage, whereas on the mainland beneficiaries are automatically enrolled in Part B and must opt out to decline it. As a result, the proportion of the population in Puerto Rico with Part B coverage is lower (46 percent) as compared to the proportion of the population that is enrolled in Medicare Part B on the mainland (91 percent). Given this differential, and because beneficiaries who enroll in Medicare Advantage are enrolled in both Part A and Part B, we concluded the FFS rate calculation in Puerto Rico should be based exclusively on beneficiaries who are enrolled in both Part A and Part B. This refinement was included in the FFS rates that CMS' Office of the Actuary calculated and was announced in the 2012 Rate Announcement published on April 4, 2011. This change resulted in an increase of 0.4% in the blended benchmark for Puerto Rico in 2012.

We have thoroughly reviewed the methodology used to calculate FFS rates and believe that the refinements made last year have achieved the best and most accurate estimate of FFS costs in Puerto Rico. I appreciate the concerns you have raised regarding Puerto Rico and look forward to working with you in the future to ensure a strong MA program is available to beneficiaries who live in Puerto Rico.

The Honorable Charles E. SchumerNational Asthma Control Program funding:

Over 25 million Americans – including 7 million children – have asthma. Asthma hospitalizations cost New York \$535 million in 2007, and Medicaid spent \$170 million that same year on asthma-related services in New York. Not only does asthma claim the lives of nine Americans each and every day, it is a leading cause of school absences and accounted for over 1.9 million lost school days in New York. Asthma hospitalizations cost New York \$535 million in 2007, and Medicaid spent \$170 million that same year on asthma-related services in New York.

Learning to control and manage asthma is key to maintaining a normal, healthy life. And the National Asthma Control Program at the Centers for Disease Control and Prevention does just that – it is working to integrate and coordinate the public health response to asthma control. Working through states, the National Asthma Control Program has made great strides in collecting data on asthma and making sure patients understand how to manage their disease so they have fewer attacks, or episodes. Since 1999, deaths and hospitalizations due to asthma have decreased – which saves Medicaid and our health systems money – even though the number of Americans diagnosed with the disease has risen.

Asthma is an epidemic in New York with significant public health and financial consequences. It is a common childhood chronic disease and a leading cause of school absenteeism. Over 1.3 million adults (9.8 percent) and almost 415,000 children (10 percent) in New York have asthma. In some areas, the rates are even higher with one in four children having asthma, which is one of the highest prevalence rates in the country. While asthma hospitalizations have been declining due to New York's action to control asthma, asthma hospitalization rates in New York remain more than two times the Healthy People 2010 Objectives.

1. Secretary Sebelius, why does the President's Budget again propose to eliminate the small but mighty National Asthma Control Program when it has made such a tremendous difference in New York and the other states that receive these critical funds?

Answer: Thank you for your concern about the burden of asthma in New York and other states and for your support and recognition of the work that has been accomplished by the National Asthma Control Program through its state partners.

Asthma is a common disease on the rise with significant health disparities and associated healthcare costs. CDC has been working with states for over 10 years to implement community-based interventions, build community-based coalitions, and track the disease burden of asthma. Our efforts have helped people with asthma control their disease and live healthier, more productive lives.

While asthma prevalence has increased over the last 10 years, national trends show that more people with asthma are controlling their disease:

- 1.7 million fewer people had asthma attacks in 2009.
- 1400 fewer people died in 2007.
- \$3.96 billion were saved in hospital bills because 233,000 fewer hospitalizations occurred due to asthma in 2008.

The FY2013 President's Budget proposes a new program—Healthy Home and Community Environments—that will incorporate the National Asthma Control Program (NACP) and the Healthy Homes/Lead Poisoning Prevention Program (HHLPPP). The FY 2013 request for the Healthy Home and Community Environments program is \$27.3 million.

The Healthy Home and Community Environments program is a new, multi-faceted approach to address healthy homes and community environments through surveillance, partnerships, and implementation of science-based interventions to address the health impact of environmental exposures in the home and to reduce the burden of disease through comprehensive asthma control. This integrated approach aims to control asthma and mitigate health hazards in homes and communities such as air pollution, lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, unsafe drinking water, and the absence of smoke and carbon monoxide detectors. CDC surveillance activities will continue to be used to identify populations at-risk or with significant disparities in order to target interventions.

The Honorable John Thune**CLASS Act**

In October, you announced that HHS is not moving forward with the CLASS Act. However, it was one year ago at this exact hearing on the budget, you told me that the CLASS Act is “totally unsustainable.” I was shocked this fall when the President said that he opposes repeal of the CLASS Act after you made the determination that it is not fiscally sustainable. Some, including former OMB Director Peter Orszag, have advocated that CLASS implementation should move forward after the statute is amended to make participation mandatory.

1. Do you support keeping CLASS on the books in order to attach a mandate to it to require all Americans to participate?

Answer: We support having a substantive dialogue with all interested stakeholders, including people with disabilities, workers trying to plan for their future, private insurers, and Members of Congress as we continue to seek real solutions. As reflected in the Department’s October 14, 2011 report to Congress, we conducted extensive analyses during the 19 months after the law passed and came to the conclusion that there is not a pathway forward at this time. While we have had to suspend our work on implementing CLASS, we believe that our work on CLASS implementation has shed valuable light on the need for workable solutions to our long-term care financing challenges, and we remain committed to making sure that the American people will be able to finance the long-term care they may need.

In December 2011, Howard Glickman wrote an article in Health Affairs that stated that HHS knew in early 2010 – *prior to the passage of the health law*– that the CLASS Act wouldn’t work. Yet, your announcement that the CLASS Act won’t be implemented didn’t come until October 2011, which was 8 months after you told me in this very hearing room that the program was “totally unsustainable.” It seems as if you have known for some time that the CLASS Act wouldn’t work.

2. Why didn't you announce your conclusion that it wouldn't work in 2010 when that decision was made?

Answer: As reflected in the comprehensive report published by the Department in October 2011, questions about CLASS solvency were well known and widely discussed prior to enactment of the CLASS Act. HHS also made these concerns clear to the public and Congress. The CMS Chief Actuary, Rick Foster, published three actuarial analyses before enactment that raised questions about the financial sustainability of the proposed program. All three were publicly available, posted online, and transmitted to Congress. The concerns raised in these analyses were discussed at HHS and in published analyses by other groups, as well as in news reports. At the same time, the Congressional Budget Office, which is responsible for assessing the budget implications of legislation, described in detail for Congress the risks associated with various program features, but projected that the program could be viable.

The CLASS Act clearly contemplates that benefits will be paid solely using premiums paid by enrollees. It also directs me to set initial premiums at a level that will ensure the solvency of the program for 75 years, and sets other benchmarks for assessing solvency after the program is up and running. I stated repeatedly that I would only implement the law if this solvency requirement could be met. As reflected in the Department's October 14, 2011 report to Congress, we conducted extensive analyses during the 19 months after the law passed and came to the conclusion that there is not a pathway forward at this time.

3. In 2010, did you talk to CBO about your determination that it could not be implemented? If you didn't, why not?

Answer: As noted in my response to Question 2, above, questions about CLASS solvency were well known and widely discussed prior to enactment of the CLASS Act. HHS made these concerns clear to the public and Congress. CBO, which is responsible for assessing the budget implications of legislation, described in detail for Congress the risks associated with various program features, but projected that the program could be viable. See, for example: http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf.

Indian Health

As you know, the Indian Health Care Improvement Act (Section 192) created a new Contract Health Service Delivery Area (CHSDA) for North and South Dakota to allow IHS to provide Contract Health Services (CHS) to members of Indian tribes located within these states. In practical terms this will allow tribal members, who do not live on a reservation, to receive contract health services. While I applaud this goal, I think we both know the limitations of the current CHS program.

4. Can you provide me with an update on its implementation? Also, how does IHS plan to fund CHSDA when IHS already struggles to fully fund all priority one CHS cases?

Answer: Implementation of the provision authorizing a new Contract Health Service Delivery Area for North and South Dakota is under review and pending additional appropriations. Expanding Contract Health Services eligibility without additional appropriations would diminish services to existing patients which is prohibited under this authority. The FY 2013 President's Budget requested an increase for the CHS program. If the requested increase is funded, IHS, in consultation with the Tribes, will consider allocating a portion of the increase to the new CHSDA in the Dakotas.

COMMUNICATION

Comments for the Record
United States Senate
Committee on Finance
The President's Fiscal Year 2013
Department of Health and Human Services
Wednesday, February 15, 2012, 10:30 AM
By Michael G. Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304

Chairman Baucus and Ranking Member Hatch, thank you for the opportunity to submit these comments for the record to the Senate Finance Committee. The beginning of the budget debate for a new year brings with it the opportunity to rethink proposals. The Center for Fiscal Equity is using this opportunity to change our proposed fix for Social Security and Health Care. As always, our proposals are in the context of our basic proposals for tax and budget reform, which are as follows:

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of \$100,000 and single filers earning \$50,000 per year.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Discretionary activities of the Department of Health and Human Services would be funded by the VAT. While some of our VAT proposals call for regional breakdowns of taxing and spending, they do not for this department. While some activities, such as the Centers for Disease Control, exist outside the Washington, DC metro area, even these are site specific rather than spread out on a nation-wide basis to serve the public at large. While some government activities benefit from national and regional distribution, health research will not.

The one reform that might eventually be considered in this area is to more explicitly link government funded research with ownership of the results, so that the Department might fund some of their operations with license agreements for some of the resulting research, enabling an expanded research agenda without demanding a higher budget allocation.

Of course, regionalization is possible if the Uniformed Public Health Service is put into the role of seeing more patients, particularly elderly patients and lower income patients who are less than well served by cost containment strategies limiting doctor fees. Medicaid is notoriously bad because so few doctors accept these patients due to the lower compensation levels, although we are encouraged the health care reform is attempting to reduce that trend. Medicare will head down that road shortly if something is not done about the Doc Fix. It may become inevitable that we expand the UPHS in order to treat patients who may no longer be able to find any other medical care. If that were to happen, such care could be organized regionally and funded with regionally based taxes, such as a VAT.

The other possible area of cost savings has to do with care, now provided for free, on the NIH campus. While patients without insurance should be able to continue to receive free care, patients with insurance likely could be required to make some type of payment for care and hospitalization, thus allowing an expansion of care, greater assistance to patients who still face financial hardship in association with their illnesses and a restoration of some care that has been discontinued due to budget cuts to NIH.

The bulk of our comments have to do with health and retirement security.

One of the most oft-cited reforms for dealing with the long term deficit in Social Security is increasing the income cap to cover more income while increasing bend points in the calculation of benefits, the taxability of Social Security benefits or even means testing all benefits, in order to actually increase revenue rather than simply making the program more generous to higher income earners. Lowering the income cap on employee contributions, while eliminating it from employer contributions and crediting the employer contribution equally removes the need for any kind of bend points at all, while the increased floor for filing the income surtax effectively removes this income from taxation. Means testing all payments is not advisable given the movement of retirement income to defined contribution programs, which may collapse with the stock market – making some basic benefit essential to everyone.

Moving the majority of Old Age and Survivors Tax collection to a consumption tax, such as the NBRT, effectively expands the tax base to collect both wage and non-wage income while removing the cap from that income. This allows for a lower tax rate than would otherwise be possible while also increasing the basic benefit so that Medicare Part B and Part D premiums may also be increased without decreasing the income to beneficiaries. **Increasing these premiums essentially solves their long term financial problems while allowing repeal of the Doc Fix.**

If personal accounts are added to the system, a higher rate could be collected, however recent economic history shows that such investments are better made in insured employer voting stock rather than in unaccountable index funds, which give the Wall Street Quants too much power over the economy while further insulating ownership from management. Too much separation gives CEOs a free hand to divert income from shareholders to their own compensation through cronyism in compensation committees, as well as giving them an incentive to cut labor costs more than the economy can sustain for consumption in order to realize even greater bonuses.

Employee-ownership ends the incentive to enact job-killing tax cuts on dividends and capital gains, which leads to an unsustainable demand for credit and money supply growth and eventually to economic collapse similar to the one most recently experienced.

The NBRT base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

A key provision of our proposal is consolidation of existing child and household benefits, including the Mortgage Interest and Property Tax Deductions, into a single refundable Child Tax Credit of at least \$500 per month, per child, payable with wages and credited against the NBRT rather than individual taxes. Assistance at this level, especially if matched by state governments may very well trigger another baby boom, especially since adding children will add the additional income now added by buying a bigger house. Such a baby boom is the only real long term solution to the demographic problems facing Social Security, Medicare and Medicaid, which are more demographic than fiscal. Fixing that problem in the right way definitely adds value to tax reform.

The NBRT should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. Such a shift would radically reduce the budget needs of HHS, while improving services to vulnerable populations.

The NBRT could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions. This is a feature that is impossible with the FairTax or a VAT alone.

To extract cost savings under the NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit, provided that services are at least as generous as the current programs. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed. Increasing Part B and Part D premiums also makes it more likely that an employer-based system will be supported by retirees.

Enacting the NBRT is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a “balanced budget” rate. It could be set lower if the spending categories funded receive a supplement from income taxes. These calculations are, of course, subject to change based on better models.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

