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PRESIDENT'S FISCAL YEAR 2007 BUDGET (MEDICAID AND MEDICARE PROPOSALS)

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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PRESIDENT'S FISCAL YEAR 2007 BUDGET (MEDICAID AND MEDICARE PROPOSALS)

THURSDAY, FEBRUARY 9, 2006

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

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Snowe, Smith, Crapo, Baucus, Conrad, Bingaman, Lincoln, Wyden, and Schumer.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. We welcome Secretary Leavitt to discuss the President's spending proposals in regard to Medicaid and Medicare.

The committee, of course, has a great interest in the administration's priorities within the Department of HHS. This hearing will provide the committee an opportunity to discuss the details of the President's budget.

Specifically, the President's budget proposes substantial savings in Medicare, and even some additional reforms beyond what we did last year on Medicaid. Together, these provisions would decrease spending by almost $50 billion over 5 years.

Just yesterday, the President signed into law the Deficit Reduction Act. This legislation will reduce growth of Medicare and Medicaid by $11.1 billion over 5 years.

Now, comparatively, this reduction is relatively modest, representing one-fourth of 1 percent of what Congress would otherwise be spending on these programs. However, it is a significant accomplishment and not one that was very easy to get done politically and procedurally.

It has been 8 years since Congress last passed legislation that reduced mandatory spending. As we all know, these achievements, that way, are never easy. I do not think I am going to shock anyone by saying that any more reductions of significant scope could be difficult to achieve this year.

One area that we will probably need to address is physician payments. The physician payment formula, as we all know, is seriously flawed. The Deficit Reduction Act provides a 1-year 0-percent update to physician payments. Doctors are scheduled for a 4.6 percent reduction in payments in 2007.

There is conflicting news about hospitals. Hospitals, on average, are losing money treating Medicare patients, yet, at the same time,

USA Today reports that hospitals have their highest overall margins ever.

All hospitals, of course, are not the same. Apparently teaching hospitals are making a 6-percent margin on Medicare patients, while non-teaching hospitals are losing 6 percent treating the same beneficiaries. So, there is a problem when formulas work out that way. I am sending a letter today to urge CMS to make changes that should improve the accuracy and equity of the hospital inpatient payment system.

I think an across-the-board reduction, and in some cases a freeze, to provider payments will be challenging. There may be other ways to achieve the same goal. If we accomplish the same end, I would hope everybody would be open to whatever we might propose.

One area along this line is to do more to reward quality. I fully support every effort to link provider payments to quality. I see from the budget that the administration supports differential updates to encourage physicians to report quality measures, and I compliment the administration, as they have worked with us on those things over the months as well.

But, frankly, I was disappointed that the administration is not proposing bolder steps in this area. We need to engage all providers, including physicians, nursing homes, and health plans.

We obviously need more transparency on health costs, because beneficiaries do not know what they are paying for. Data on providers' costs and quality should be publicly available to give consumers an idea of what they are buying.

Giving consumers more direct involvement in paying for their care will prompt them to shop for the best value, ultimately choosing the highest-quality and lowest-cost care. This will increase competition, resulting in improvements throughout the health care system.

If Medicare reductions do end up on the table, the Medicare Advantage Regional Stabilization Fund should be at the top of the list. This fund has not been used. There are already a good number of regional Medicare Advantage plans participating. It is clear that this fund is not needed.

I look forward to hearing more about the President's proposals on the uninsured. There are now almost 46 million Americans in that category. We do need strategies. Continued expansion of health care savings accounts, coupled with tax deductions and credits to encourage their use, is a good step forward.

I hope that we can put partisan politics aside on this issue and have a thoughtful dialogue on what is a critical issue. We must make changes to contain health care costs and reduce the number of uninsured.

Beneficiaries and taxpayers both deserve the highest value for every dollar that is spent on Medicare, Medicaid, and safety net programs. The President's budget always sets off a good debate, which we are now going to have.

I have a longer statement I am putting in the record.

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

The CHAIRMAN. Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

In the book of Deuteronomy, Moses told the children of Israel, "If there is among you anyone in need, a member of your community in any of your towns within the land that the Lord your God has given you, do not be hard-hearted or tight-fisted toward your needy neighbor. You should rather open your hand, willingly lending enough to meet the need, whatever it may be."

In our day, in our community, that job, the job of opening our hands to meet the need, falls most heavily on the Department of Health and Human Services. Today, we examine the administration's proposals on how the Department should do that job.

From the perspective of those in need, I find the administration's priorities misdirected. Administration officials may well have had the needy in mind, but the administration's proposals too often seem to extend a hand to someone else altogether.

Let me start with the administration's health savings account proposals. Over the next 10 years, the administration proposes spending $156 billion on these accounts.

To receive the tax benefits of one of these accounts, a beneficiary would have to enroll in a health insurance plan with a high deductible. Who would make that choice? People who do not expect large medical expenses would be most likely to make that choice. These are not people with health needs, and it is what health care analysts call adverse selection.

Encouraging healthier Americans to choose these accounts with high-deductible plans will make health care more expensive for those who stay behind in traditional coverage.

Sick individuals who remain in traditional coverage are more expensive to cover. Since the new accounts will encourage healthy people to leave traditional plans, the premiums for everyone else in traditional plans will rise accordingly.

Thus, these accounts will lead to a weaker health care system, not a stronger one. As the magazine, *The Economist,* wrote: "The administration's plan may speed the reform of American health care, but only by hastening the day the current system falls apart."

Yes, these new health savings accounts would make an attractive investment, but who would choose to invest in them? People who already have wealth and savings who want a tax-sheltered home for those investments would make that choice. People who are scraping to get by, people in need, would not make that choice. These accounts would, thus, not be likely to add to net savings.

Yes, it makes sense that those who spend their own money rather than their employer's will be more sensitive to the cost of health care, commonly referred to by the administration as having "skin in the game." But let us be honest with ourselves. It is not easy for the average consumer, the average patient, to know which health care services are best.

Greater transparency of price and quality information, while a good goal, will not solve this problem. Individuals overly concerned about the cost of care may cut back on cost-effective health care, and if that happens it will ultimately cost the health care system more.

I might add that this smacks, frankly, of Darwinism, the survival of the fittest. This proposal is just that. Those who are the most fit, those who are the most wealthy, those who are the most healthy, will survive; those not, not as well.

On the issue of Medicare generally, the administration's priorities are, again, misdirected. For example, the administration would reduce payments to Medicare hospitals, home care, and nursing home providers, among others. Yet, the same budget would maintain current over-payments to Medicare managed care, Medicare Advantage plans.

Medicare Advantage plans are aptly named; the folks who offer these plans have a distinct advantage. Medicare pays them far more than it costs to care for an average Medicare beneficiary, and yet Medicare Advantage plans typically enroll healthier, and cheaper, Medicare patients.

Recognizing the unfairness of this system, the Medicare Payment Advisory Commission recommended several policies last year to reduce over-payments to Medicare Advantage plans.

The recently enacted budget bill partly adopted one of MEDPAC's recommendations, but several others, including the elimination of a $10-billion incentive fund for Medicare Regional PPOs, were not included.

I, frankly, do not understand the administration's rationale for over-paying private Medicare plans, while proposing cuts for other Medicare providers. Once again, the administration appears to help those who are not in need.

I am also deeply concerned about the budget proposals that give the administration authority to make across-the-board cuts in Medicare. The administration is asking Congress to give it authority to cut all Medicare providers by four-tenths of a percent when Medicare spending reaches a certain threshold.

When we wrote the threshold into the new drug law, we created a process that would require thoughtful, targeted proposals and not mindless sequestration. This proposal contradicts that intent.

The budget's Medicaid cuts, I believe, are also misdirected.

The recently enacted Budget Reconciliation bill, which I did not support, made deep cuts in Medicaid. The President signed it yesterday. The ink is barely dry. Now the budget proposes Medicaid cuts more than twice those just enacted, $17 billion over 5 years. We should pause to ensure that we have not damaged our Nation's safety net before Congress makes further cuts.

Many of the proposals would once again target the States. The provider tax and targeted case management services reductions concern me. States rely on these funds to provide vital services to nursing home residents and at-risk populations.

The Congressional Budget Office says that these cuts will adversely affect tens of millions of Medicaid beneficiaries, yet the administration proposes more cuts in its budget.

The Department of Health and Human Services oversees critical programs that extend a hand to those in need, and, yes, we must ensure that the Department does so wisely. But let us start by making sure that we spend those dollars, first, on those in need. Let us make sure that we do not lavish benefits on those who are

not. Let us wisely extend our hands to meet the needs in this good land that the Lord our God has given us.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We have our Secretary before us, and everybody knows who he is, so I am not going to go into an introduction. We thank you for your cooperation.

I also want to follow up on yesterday's meeting, only in the sense of when you and Dr. McClellan were before the closed group, you offered to give some time lines to get things done, and we appreciate that cooperation.

We are building on that with a weekly communication between our staff and your staff. We appreciate that cooperation, and hopefully those deadlines and date lines will be met.

So, go ahead with the subject that is before us now, the budget.

STATEMENT OF HON. MIKE LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary LEAVITT. Thank you, Senator and members of the committee.

Let me, first, say I am moved by the responsibility referred to in Senator Baucus' recitation of Scripture. We do view ourselves as having the responsibility to carry out the compassionate instincts of the people of the United States.

It is a great and noble country, and a great and noble responsibility. My purpose in being here today is to talk about the ways in which we believe we can, with the most wisdom, carry that mandate forward.

The budget that we will be discussing today is a large one, $700 billion, nearly. It represents nearly 1 in 4 dollars that the taxpayers of our Nation put forward for our care and keeping and investment.

It is well known to all of you that that budget is broken into two large categories. One we refer to as the entitlement programs. These are decisions that we have made as a country to meet the specific needs of groups that we have determined collectively we will care for: the elderly, the poor, those with disabilities, people in populations that need to be cared for with specific purpose.

The second we refer to as "discretionary." It is discretionary only in the sense that it requires our year-to-year judgment on how best to prioritize the available funds.

There is concern among all of us, I believe, about the long-term implications of the obligations that we have created as a country for us to care for people we deeply care about. Medicare occupies an increasing and dramatically encroaching portion, not just of our budget, but of the entire economy.

It is rapidly growing toward double digits of the entire Gross Domestic Product. There is no one, I believe, in this room who does not believe that that is a matter of grave concern to us, economically and culturally.

So I do hope we will get a chance to talk about how we can resolve that. We will not resolve it today, but maybe in part we can begin to find ways that we can improve that trend.

On the other side of the ledger—the discretionary budget—we are at a time with substantial deficits, and they need to be reduced. The President has established a goal to reduce that deficit.

As a result, he has instructed that we put forward budgets that are both responsible, but demanding, demanding on all of us to become more innovative, demanding on all of us to find better ways to accomplish things.

So today I come to you with a budget on the discretionary side that will be $1.5 billion less than the budget that was enacted in 2006. My public service has included a fair amount of time as Governor of one of our States, and I, through the course of that time, presented budgets, some of which included the best of times when we had new money to invest, and sometimes when we did not.

I will tell you that it has been my experience, as it has been yours, that when we are reducing budgets we have to make difficult choices among programs, all of which are good because they have some redeeming, responsible person who is passionate for them.

I am going to present to you my thoughts about how we should reduce many of them today. They likely will not be the same thoughts that others have. There will be disagreement on them because there is a passionate advocate, and with good reason, for every one.

When I have concluded and the budget begins to be discussed by the Congress, you will obviously have your own views as to what we should do on this. My purpose today is to simply tell you what mine are.

Rather than to go through what is $75 billion of discretionary programs in the very limited time here today, why do I not give you a sense of my own philosophy, how I have approached this with the large group of people in the Department who have assembled this budget?

I made clear to them that I believed there were some priorities that we needed to focus on, new ideas, so this budget does have new initiatives. It has new initiatives that deal with health information technology. It has a new initiative related to our need to cover and to test more people with AIDS. It has new initiatives that deal with how we can give independence to some of our disabled persons in this Nation.

It also has a series of commitments that the President has made. For example, his commitment to expand dramatically the number of community health centers. Those are commitments that we need to cover. There is also bio-terrorism and the pandemic discussion that we have had in this committee, all of which we feel intuitively have to be covered.

Philosophically, what I did in assembling this budget was to say to my colleagues, I want to find a source for those new initiatives that can be drawn from one-time funds, for example, that will not be repeated.

I want to find programs where the purposes have been addressed a number of different places. If they are being addressed by two different parts of the budget, let us only address it one place. I have asked them to find funds that were carry-overs, to use those

funds. I have also looked for several programs in the budget that we proposed be cut last year, but were not.

So I have, frankly, gone about looking in this budget to find funds that we could apply to what we thought were important new initiatives, because they are so important in the context of things.

Then I have asked them to go through a series of steps in analyzing all of our existing budgets, a series of principles of investment. Again, rather than go through specifics, let me just articulate eight principles that I have asked them to apply to every one of the investments we are making.

The first is targeting, as opposed to replacing, general programs. You are going to find a number of places here where programs have covered a wide array of need, some who need it more than others. I have said, let us cover fewer institutions, for example, but with more money, so we will have better targeted programs, but maybe fewer of them. That is one principle.

Another is prevention. If we can find a way to prevent something as opposed to just paying for it after it has been broken or paying for a person after they are sick, that is a better principle. So you will see a number of places where reductions have been made on the basis of preventing, rather than just paying after things have gone awry.

The third principle is actually providing services. Senator Baucus talked about the need we have to provide for those who are poor, who are sick, and who need to be uplifted. Many times we are building infrastructure to do that, but not actually getting to the point of delivering service.

In times when we do not have the ability to do both, my preference is, let us help people and not just build infrastructure. It is nice and important to do both, but if you have to do one, let us focus on delivering services to people.

The fourth is recognizing that we can find ways to be efficient. We do not always make the right choices; markets will. I have looked for ways to find efficiency through markets. I have looked for ways to have individuals be able to make choices that fit their needs.

I have looked for ways to invest in new technologies when old technologies may have run their course. You will find cuts in this budget where things that we have researched for a long time were taking funds that could be used to research new technologies.

I have looked for ways to invest across the entire Department. There is a tendency, in large Departments like this, to see silos of investment. I am looking for ways to break down the walls of those silos and invest across the entire health care system or across the entire Department.

I am also looking for programs I can measure. If we cannot measure their benefit, I think there has to be some question asked about whether there is benefit.

So as we interact, there may be some areas on which we disagree, but you will find that somewhere in those principles there is a reason I have made the choice I have. I just want to be here today to obviously tell you why the decisions were made and to hear your thoughts about it.

So, Mr. Chairman, that concludes my opening statement. I am very happy to be responsive to your questions.

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

The CHAIRMAN. All right.

I will not go through the announcement I made yesterday morning, but we will go by the same rules, 5-minute rounds.

I want to bring up pay-for-performance and ask the administration to be a little more adventurous. I am disappointed, as I said in my statement, about not moving more aggressively to link provider payments to quality.

We must move past paying providers just for reporting data. We have started down that road. This is because providers can fail to do the right interventions, but still get a bonus payment.

That does not seem to me to be an incentive that would fit into the principles you just mentioned. We must adjust our systems to start paying for truly higher-quality performance.

What is the administration's long-term vision for pay-for-performance? I will just read three questions instead of waiting for answers.

What additional authority or resources do you need from Congress to move forward? How do you plan to incentivize physicians to report quality measures when they are scheduled to receive a negative 5 percent update next year?

Secretary LEAVITT. Let me, first of all, acknowledge, Senator, that nothing in government works fast enough for me either. When you are dealing with large, complex organizations, I become impatient.

But at the heart of this is the ability to collect information and measure things well. At the heart of that is the ability to use information technology to gather information so that we can measure it and begin to compensate people on the basis of the value they bring so that we are paying physicians on what they do to help patients, not just how many procedures they can perform.

There is a relationship you see. Whenever the rates go down, the number of procedures goes up. That is not providing incentives in a way that will ultimately work in the best interest of patients.

So the vision is very clear: to get beyond a system that I would acknowledge does not make a lot of sense in the way that we currently create compensation for physicians and get to the point that we are measuring performance. Now, some of that is going to have to be, again, predicated on our ability to gather information.

And while you did not raise it, I will: the most important element, in my judgment, is getting information technology standards to where we are able to gather the information, measure the quality, and then compensate the care for that purpose.

We do have, for the most part, sufficient authority to do it. There may be a need for us in the future to come back for additional authorities as we perfect this, but, as you know, we are currently going through a series of pilots that are showing quite a bit of promise.

We have to work together with the medical community. This is not something that we should just do unilaterally. We have to work collaboratively. They certainly have enough incentive, because their

payment rates are at stake, and we have incentive, because we have to find a solution to this.

The CHAIRMAN. My perception is—and it is more from news media reports, and that may not be the best place to get your information—that various corporations—major corporations; you know their names as well as I do—are moving very quickly in this area, seeking the best return on their dollar in health care for their retirees.

I guess I feel a little bit embarrassed that we in government, spending 45 percent of the health dollar out of the Federal treasury, cannot do more. So, we just need to do more.

My next question. The President's budget includes significant funding for a variety of quality initiatives, including funding for quality improvement organizations. A study published by the *Journal of the American Medical Association* last year found little difference in performance between QIO-participating hospitals and non-participating hospitals. Do you feel that QIOs have accomplished the goals set out in the seventh scope of work?

Let me ask an additional question at this point. The President's budget notes that the most recent QIO contract shifts the focus of the QIO activities to promote quality and efficiency. Is there any concern that the QIOs may not be able to successfully accomplish these tasks?

Then, lastly, what evidence is available that supports the choice of QIOs as the most appropriate entity to take on the new tasks that are in the President's budget, such as assisting the adoption of health IT among physicians' offices across the country?

Besides your oral answer, I would like to have you submit evidence to my staff in addition. Go ahead.

Secretary LEAVITT. Thank you, Senator. We will respond to your question in writing.

May I just emphasize, again, that none of us is meeting our aspirations to move as fast as we would like? That is true, not just for government-paid programs, but also the corporate interests who want to see more efficiency with their health plans.

At the heart of this is a mission that has recently been given to QIOs, which is to help the medical community begin to adopt health insurance technology. For us to get to pay-for-performance, for us to get to a higher level of efficiency, for us to be able to start supplying patients with information on their health so that they can become more involved in the decisions, we need to harness the promise and the capacity that health information technology provides to assist in making quality decisions.

Now, there is a significant part of this budget devoted to bringing that about. I just want to acknowledge that it is happening. It is not happening nearly fast enough for me, and obviously for you either. I believe the QIOs can play a productive role, but it is going to have to be united in a broad effort, not just with QIOs, but across the board.

The CHAIRMAN. Well, what about the AMA journal finding little difference in the performance between QIO-participating hospitals and non-participating hospitals?

Secretary LEAVITT. That bears investigation.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, is the premise of HSAs not also the reason for their deficiency? Namely, if people have choices—the "skin in the game" argument the administration makes—that, if people make choices, they will choose what makes the most sense for them. On the surface, that sounds nice, sounds good.

But if someone chooses what is best for him or her, and if he or she is healthy, will he or she not choose to purchase an HSA? If somebody is chronically ill, an aged person, will he or she choose not to purchase an HSA because of the deductibles?

Would the result not therefore be that so much of the cost of health care is passed along to those in need, and, therefore, is the whole premise of HSAs not the reason for us to be most concerned? That is, they would raise the cost to people who do not purchase because they wisely choose not to?

Secretary LEAVITT. Senator, just a couple of areas where I would have some disagreement with your thoughts about this.

One is the implication that those who have HSAs are left without money to pay the deductible amounts. They have money, it's just money that they can save if they find a more efficient way.

They have the money. It is not like they are left without a capacity to make those expenditures. They can; it is just money that, if they can find a more efficient way, there is an incentive for them to do it.

Now, if they do not do it, they can spend it. If they spend it, then they get to the point where they have full insurance and the insurance company pays it. It is just providing them with an incentive.

Frankly, the worry that there will be some kind of adverse selection just has not been borne out. We now have 3 million of these, and they are growing rapidly. Nearly 40 percent of those who sign up are people who did not have insurance before, and they are people who make less than $40,000 a year.

We are simply putting insurance within the reach of a population that, at this point, does not have it. It has the side benefit, in some cases, of being able to provide some level of incentive for them to be cost-conscious consumers.

Senator BAUCUS. I am not going to get into an argument with you over this, but frankly I think the true number is 1 million, not 3. The 1 million is the new, the remaining 2 million are people who already have high-deductible health plans. So the honest—and I am not saying you are dishonest—and accurate figure is 1 million, frankly.

Secretary LEAVITT. Senator, I signed up. I am one of the 1 million. I signed up for one a year ago. I can just tell you the experience I have. The amount of money that is there available for me for health care is the same as I had before, but for the first time in my life I understand now how much my prescription drugs cost. I just went to the drug store and gave them the card.

Senator BAUCUS. I understand. But a lot of people are not very wealthy and they will not choose to buy an HSA because they do not want to have to pay up to the deductible, first.

Secretary LEAVITT. The way an HSA works is, they are provided the money that they need, just like they would with first-dollar insurance.

Senator BAUCUS. It just smacks of Darwinism to me, survival of the fittest. If you are fit and healthy, wealthy and wise, you get an HSA, particularly when the limits are raised, as proposed, from $1,000 to $5,000. If you are not, you cannot, and you do not. It is pretty simple.

Secretary LEAVITT. But it is a good thing to have people signing up to have insurance. It is a bad thing if they do not have it. Forty percent of the people who are getting them did not have any insurance before for some reason.

Senator BAUCUS. I am just curious about the administration's rationale for Medicare cuts. At Ways and Means yesterday you said, basically, the cuts are consistent with the most recent recommendations of MEDPAC. But as you know, the MEDPAC recommendations are 1-year recommendations with respect to Medicare, but the President's proposals are generally for 3 years.

Second, MEDPAC also recommends doing away with the Medicare Advantage advantage that those plans have. It seems like you are picking and choosing from MEDPAC, with the result that it is hurting people who need help and helping people who do not need help.

Secretary LEAVITT. I view MEDPAC as being one voice that can provide advice. We ultimately have to be responsible for the decisions that we make, and we will be.

I will give you an example: the market basket, reducing by fourtenths of 1 percent the market basket recommendation. As pointed out, hospitals are in good financial times, most of them.

At least the reports in the news media are that they are making more money now than they have been in the past. Plus, this is a pattern that has been followed for a decade or a decade and a half, that we have not funded the entire market basket because it provides some incentive for efficiency.

Now, I know there will be hospital administrators who will question what I just said, but I am responding to global numbers I have been provided. We think it is not a bad idea at all for hospitals to have to find ways of innovating, and this is one way of incenting them.

Senator BAUCUS. You only answered half the question. What about the Medicare Advantage over-payments? The hospitals are doing all right; the Medicare Advantage plans are doing really all right. So why are you not also addressing that as well?

Secretary LEAVITT. As I dig into this, what I find is that it is primarily focused on making certain that we have the availability of plans in areas like Montana, and Iowa, and Utah, and North Dakota, because we need to make certain that we can provide those plans on a national basis so that there is choice in the capacity to have those services. I think that is not just reasonable, but an affirmative policy.

The CHAIRMAN. I will pass over a couple of people who temporarily had to step out and go to Senators Smith, Conrad, Lincoln, then Snowe. If members who have been here come back, then I will go back and pick them up, so do not feel like I am neglecting you.

Senator Smith?

Senator SMITH. You can cut me off as soon as they arrive, Mr. Chairman.

The CHAIRMAN. Well, I do not mean in the middle of your questions. [Laughter.]

Senator SMITH. I am just giving you permission.

The CHAIRMAN. All right.

Senator SMITH. Thank you, Mr. Chairman.

Secretary Leavitt, it is a pleasure to be in your company today. I appreciate very much all the work that you do.

I do not know you well, but I think I know your heart. I think what Senator Baucus read from Deuteronomy is an ethic that you and I share in common. I am really on the horns of a dilemma this morning, because I was prepared to ask you to help me with funding on SSI, youth suicide prevention, and a whole range of issues that affect the poor, disabled, the needy, and the elderly. I have fought for those issues because I care about them and believe in them, for the reasons that I think Senator Baucus articulated.

But I am also mindful that we are just playing around the edges here. I recently saw—from materials that Senator Gregg and Senator Conrad provided to us that make it clear—that in 25, to the outside 35, years, your Department is going to be the only Department of the Federal Government because three programs—Social Security, Medicare, and Medicaid—will consume all Federal revenues.

What that means is, no money for defense, no money for homeland security, no money for farms, no money for schools, no money for the pet projects I have. I have tried to fight for the poor, and I voted for medical savings accounts.

My office has a schedule lined up for me with request after request of Oregonians with honorable and legitimate concerns and requests from the Federal Government. I do not know what to tell them any more. I care about what they care about, but we are just kidding ourselves here.

I know my friends there would like us just to raise taxes. I think, all right, what will that do to America? That is what Europe has done to Europe. They have even more generous social benefits. They have much higher taxes. They are going to hit the wall before we do.

So I am just wondering if, in your deliberations with the White House, if we are really squaring with the American people about the ticking time bomb that we are all sitting on as a Nation.

I mean, I do not know. It just seems to me that we are going to have to soon come to a place where Republicans and Democrats become Americans first and figure out how to save our country, because you are the only Department in government that is going to be around in 25, 30 years on the current track.

Do you have a comment?

Secretary LEAVITT. Well, Senator, only to add to the weight of the quite remarkably weighty things you have already said. Not only would it be the only Department in the Federal Government, but we will have eroded the capacity of State governments to provide public education because Medicaid will have overtaken not just education, but virtually every other budget in State government by that time.

At the heart of this is health care. Health care, in 1960, was 5 percent of our Gross Domestic Product. Today, it is 16 percent. One

program, Medicare, today is 3.4 percent of our Gross Domestic Product. One program. There is little doubt that no society can sustain that kind of erosion of its economic competitiveness.

The jobs that ultimately create the capacity for the tax revenues to be developed will diminish and we will be left without the capacity to do it. In fact, one could argue that that day will be hastened by that systemic collapse.

Now, how do we resolve it? Well, I think there are some very basic principles we have to begin to fall back on. One is, we have to change the way we think about health care. It cannot be just about how we treat people after they are sick, it has to also be about helping people stay healthy.

That is not just a government program, it is about us being willing to take on the issues like obesity and chronic disease. It also means we find more efficient ways to do it.

We have talked about health information technology. That is one example of the way we can provide information, not just to individuals on their own health, but to institutions on who is doing what well so it can be implemented. We all have to recognize that there are limits. Your time is up, and I have used a good share of it.

Senator SMITH. Well, no. I mean, I think you and I both understand the problem. I think we all do. I hope you will forgive me as I push for full funding of the Garrett Lee Smith Act. I am going to do it again. Other things I believe in, I am going to fight for. But I would say to my Democratic colleagues, I am willing to talk, because we are kidding ourselves.

Secretary LEAVITT. I think this is the reason the President has proposed a bipartisan approach to an Entitlements Commission that could begin to examine things, not for just this generation, but for generations to come.

Senator SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. First of all, I want to associate myself with the remarks Senator Baucus led off with that I thought were right on point on a whole series of subjects.

I want to associate myself with the questions of Senator Smith. I would say to my colleague, at least for this Senator, I do not think tax increases are the first place we ought to look, even on the revenue side.

I believe the first place we ought to look is the tax gap, the difference between what is owed and what is being paid. The Internal Revenue Service says that is now $350 billion a year. I believe that is an under-estimate. That is the first place we ought to look because, clearly, you have to deal with both the spending side of the equation and the revenue side.

Mr. Secretary, first of all, you know that I have respect for you. I have told you that privately, I have said it publicly, and I mean it. I think you are a fine man. I was delighted to meet your father this morning and to be able to say to him, you did very well in raising this man.

I expressed yesterday my profound disappointment with what has happened in the prescription drug program roll-out. It has not gone well. That is an understatement in my State. I think it has been chaotic. I am hearing from pharmacists that they are thinking

of dropping Medicare patients because of how this has been handled. That would truly make this all worse.

As you know, representing Utah as Governor, rural States are different than some of the more urban States. Let me go to some of the budget recommendations.

You have adopted what was described as MEDPAC's recommendations, but you have adopted their proposals for 3 years and they have only made a 1-year proposal. So I do not think it is quite fair to say these are MEDPAC's proposals with respect to hospitals, nursing homes, home health care, and the rest.

Kind of the impulse here is that hospitals have high margins, higher than normal. That is true in parts of the country. It is distinctly not the case in the part of the country I represent. If you take out the four largest hospitals in North Dakota, and there are 42 hospitals in my State, the margins are, for the rest, in the negative, a negative 1 to 2 percent.

So, help me understand. What is going to happen to those hospitals that are already under pressure if this proposal goes forward?

Secretary LEAVITT. Senator, you have raised concerns about two sectors of the health care economy: the pharmacists and the hospitals, and in particular, rural hospitals. Senator Smith, on the other hand, has pointed out how health care, generally, is encroaching on our Gross Domestic Product in a way that it borders on the point where it will begin to cost our economic competitiveness.

Any time we begin to put constraints on any part of the economy and it begins to feel its economic equation constrained, there is a struggle and a worry. People cry out and they, properly, bring attention to their dilemma.

There is a long list of people within the health care system who are doing the same thing right now. But for the reasons that Senator Smith has indicated, we have to find ways of becoming more efficient.

If we go too far and people begin to be adversely affected to the point that they cannot deliver services, then perhaps we have to adjust incrementally. But we are providing in this budget at least our read on how we can begin to constrain health care costs in a program that is ultimately going to eat up our capacity to be prosperous as a Nation.

Senator CONRAD. If I could just intercede on that point and say to you, look, I do not think anybody is more acutely aware of the need for fiscal restraint than this Senator, as Ranking Member of the Budget Committee. I believe deficits matter. Unfortunately, there are increasing numbers of people in this town who do not think so. They clearly do matter.

But when I look at the choices here, Medicare Advantage, by reasonable estimations, the MEDPAC proposal there could save $30 billion over 10 years, and you have not adopted the MEDPAC proposal there at all. Why not?

Secretary LEAVITT. As I indicated before, MEDPAC is only there to advise. We ultimately have to be responsible for our own policy recommendations. These are our recommendations. It is our view

that it is important to have the Medicare Advantage plans, for example, operating in areas like North Dakota and South Dakota.

One of the reasons it is important to have them treated in the way that this budget proposes is so they can, in fact, operate, and operate in a way that is financially consistent with the needs of the hospitals. If they are paid more in North Dakota, it is because the hospitals there require it.

Senator CONRAD. I would just conclude by saying, as I look at this budget, it is distinctly unfriendly to a rural State like mine. I look at the cuts in rural health programs, 83 percent cut, and the effect on hospitals in my State.

I would just say to you, I do not think we can just put all the hospitals in the same category, because, as you know, there are really vast differences.

I appreciate the Chairman's indulgence.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. Thank you, Mr. Secretary.

I am a little bewildered on that last question. Medicare+Choice has always cost more. I do not know why we think it is going to all of a sudden get less expensive because we supplement it and you keep it in those areas. It served so few of those areas in the past, I do not know why that is going to change. I will save that confusion for later.

Mr. Secretary, I have a couple of specific questions about the budget. Again, as my other colleagues, I would like to associate myself with the previous comments from Senator Baucus and Senator Smith.

I agree, we are digging a hole. As far as making difficult choices, moving forward, and working together, it just does not seem to be happening as much as many of us would like that to happen.

Specifically, in the President's proposal, in his budget, Mr. Secretary, there is a reduction in the ambulance fee schedule by $10 million in 2007 and $290 million over 5 years.

Many ambulance providers in Arkansas have just closed over the past year. Those that have remained have tried to absorb those that were closed. They have struggled to stay afloat.

In fact, I just heard from one of my ambulance providers yesterday that CMS has frozen the Medicare payment this week. These providers are the backbones of our communities.

They certainly have to meet the same regulations that other ambulance providers in other areas do, but when you find that these ambulance providers are providing those same regulated services on one to two calls a day compared to their competitors that may get 25 calls within one city block of Manhattan, they are put at an extreme disadvantage, particularly when they see these fee schedules and, again, frozen Medicare payments.

I just have to add that many of our providers performed heroic work during the aftermath of Hurricanes Katrina and Rita in the Gulf Coast. We are one of the neighbors to the north. We absorbed about 65 evacuees.

But almost all of our southern ambulance providers left and went to the distressed region. Many of them were shot at. They were put

in despicable conditions. Yet, they stayed there and served those who needed to be served. Some of them are still there.

So it is so important, I think, to consider, as Senator Conrad just mentioned, not all hospitals are alike, not all regions are alike, and certainly the needs and concerns that exist there.

So I guess my ultimate question on that would be, what is your reason for cutting the Medicare payments to the ambulance providers? This was not a MEDPAC recommendation, and certainly the freeze that CMS has put on those payments this week is an added concern.

Secretary LEAVITT. A couple of general comments. My father is here, but my grandfather once said to me, if you are trying to get yourself out of a hole, the first thing to do is to stop digging.

I think that really leads back to Senator Smith's comment. There is not a part of this budget, that if it was listed with any kind of reduction, that there would not be a sense of pain associated with it.

Now, with respect to the ambulance systems, may I just say we are not cutting anything. We are slowing the growth in their reimbursements, that is it. We are just slowing the growth.

Senator LINCOLN. I just think it is so important, because my providers have said to me, they do not have a problem being a part of that reduction and understanding that there is pain involved, but disproportionately, for these types of providers, I think it is so important that we recognize that they are providing a service, meeting the same regulations as providers in urban areas.

They are doing it on much less because, by nature in a rural area—I mean, I have one ambulance provider that is covering five counties because no one else is willing to do it.

The hospitals are shutting down their services. They are not providing ambulance service any more. The private industry ambulances could not even get on the list during the aftermath of the Gulf Coast disaster in order to get the repayment for what they did.

So I do not think that they are unwilling to share in the pain. The problem becomes, their pain is so disproportionately different, particularly in rural areas. There is a great concern on my part there.

Secretary LEAVITT. Thank you.

Senator LINCOLN. Yes. I understand.

The CHAIRMAN. Senator Lincoln, your time is up.

Senator Schumer, let me explain that you and Senator Snowe were here before and you had to temporarily step out. So, I will now call on you.

Senator SCHUMER. Mr. Chairman, I was thinking on the way over, you handled the order in which people are called in a very fair, midwestern way. All the other committees should be so fair.

The CHAIRMAN. Well, tell the rest of the people from New York that, would you? [Laughter.]

Senator SCHUMER. Yes. They all know.

Thank you for being here, Mr. Secretary. My first question is on generic drugs. I am just always surprised how the administration, which is very concerned with cutting costs, has a blind spot when it comes to the difference between generic drugs, which are much

cheaper, and brand-name drugs. I really can only attribute this to not such good reasons.

So, let me ask you about this one. Your budget would cut payments to pharmacies for generic drugs—you know there is a payment to pharmacies for handling drugs—but do nothing to brand drugs that are still on patent.

In other words, what you are doing is, you are trying to save some money by cutting the payments to the pharmacies, but you are sort of pushing them—because they do better when they handle the brand-name drug than the generic drug—to distribute the brand-name drug.

There is a cut here on generics—where the generic alternative exists—from 250 percent of the average manufacturer price to 150 percent. Why did you not do the same with brand-name drugs? If you were going to cut the generics, why not cut the brand-name drugs? It is going to save. It may not save it in this budget year, but it is going to save the country money in the long run.

Secretary LEAVITT. Senator, I am not able to respond adequately to that. I do not know the answer to it. I can tell you that we are doing all we can, that I am aware of, to promote the use of generic drugs, both in their manufacture, approval, and distribution, and incent people.

Senator SCHUMER. All right. Could you get back to me in writing what the rationale is?

Secretary LEAVITT. I would be happy to. It is not something I can reconcile.

Senator SCHUMER. And why there is a difference. I would urge you to do the same for each. If you feel you have to cut the pharmacy costs, you can show us the information on that. But to do it for generics and not for brand-name drugs just defies logic, if you want to save money and keep care good.

Second, I would like to follow up. I had a discussion yesterday with Administrator McClellan on formularies. Senator Feinstein and I, Senator Bingaman, Senator Snowe, three of us on this committee, we have introduced a bill to prohibit Medicare drug plans from changing their drug lists for seniors who have already committed to their plans for a year.

A senior will sign up with one plan because, say, it has Norvasc. Then the company is allowed to change and get off and say, we are not using Norvasc, we are using some other drug, and the person is stuck.

Now, Administrator McClellan said that this is not happening, that the plans are not switching, getting in and out of drugs. But we have heard evidence to the contrary. Can you tell us what can be done in this situation?

Secretary LEAVITT. Senator, you have introduced legislation. That will be a policy question that will be debated by the Senate and decided. In the meantime, I can tell you this.

Senator SCHUMER. Great.

Secretary LEAVITT. There is a process under which plans can change their formulary, but it does require that they seek approval of HHS through CMS, and that is a rigorous process through which they have to go to do it.

Now, I asked the same question, is it happening? I am told the same thing he told you, and that is, it is not happening. If it is happening, or if it does begin to happen, they will be rigorously scrutinized, for the very reasons you pointed out. We are trying to get people into plans that fit their need.

Senator SCHUMER. Right.

Secretary LEAVITT. And if they are not in a plan that fits their need, we want them to be able to make a change to the plan that does.

Senator SCHUMER. Right.

Secretary LEAVITT. The goal is the same: let us make certain that people get the drugs they need, when they need them.

Senator SCHUMER. Could I ask you to submit in writing how many have applied to drop a drug and how many have been approved?

Secretary LEAVITT. That is a simple, and I believe fair, request.

Senator SCHUMER. Thank you.

All right. I do not have my glasses here, but I do have another question. This is on Tamiflu. As you know, we have been involved, and I want to salute you on your demonstrated commitment to preparing the Nation to deal with Tamiflu.

Now, I have worked to ensure that stockpiles of Tamiflu become a reality. I think that the experts say there should be enough for about 40 to 50 percent of the population.

What has happened, I think, in the administration, is that there has been a push. You folks only have 5 million courses on hand, less than the 100 million that would be around the 40 to 50 percent mark. You are trying to push most of the cost on the States.

Yet, when we talk to the States, they are not doing it. It is sort of, we are in an Abbot and Costello situation here. The States say the Feds should do it, the Feds say the States should do it.

Tell us your view on this. What is going to happen if the States do not live up to their part of the bargain? Their budgets are stretched as well. Could you please comment?

Secretary LEAVITT. Yes. Thank you. I heard your comments on this before, and I am anxious for a chance to reconcile it.

Actually, the World Health Organization, as well as our own planners, recommend not 50 percent, but 25 percent for the population, which brings the number down to 81 million courses, which is our target.

Senator SCHUMER. Right.

Secretary LEAVITT. We have orders placed.

Senator SCHUMER. That is because of my glasses that I got the numbers wrong.

Secretary LEAVITT. That is fine.

Senator SCHUMER. Or lack thereof.

Secretary LEAVITT. We have orders placed that would get us to our first target, which is 20 million courses by the end of 2006.

Senator SCHUMER. Paid for Federally?

Secretary LEAVITT. Paid for Federally. And I am in the midst of a round of 50 Pandemic Summits with the States, where I am signing MOUs with each of the Governors, whereby, the 1st of July, they will provide to me information about how much additional Tamiflu they might require above their allocation.

We are going to buy 50 million courses and allocate it to the States, then anything from 50 million up to the 81 million we will subsidize if they choose to acquire some in addition.

In net, we will be paying for 70 percent of the Tamiflu that goes into the hands of States and will be controlled in the distribution, for the most part, upon priorities that the States elect.

Senator SCHUMER. All right. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you very much.

Thank you, Mr. Secretary, for being here and allowing us each to ask our questions. Let me ask about this issue of health care for American Indians. In my State—and I think maybe we visited on this before—if you had to identify a group in the population that gets inadequate health care, it is the Native American community, I would say, even more than the Hispanic community, than everyone else combined.

More and more of the people in the Native American community, more of the Indian citizens of my State, are moving to urban areas, so I am very concerned that they continue to have access to health care when they do that.

As I understand your budget proposal, it is to eliminate funding for urban Indian programs. Now, in Albuquerque, for example, there are over 30,000 Native Americans who are served either by the Albuquerque Indian Health Center or what is now called the First Nations Health Center. The Indian Health Center's funding was $13 million a couple of years ago; now it is down to $5 million. It is proposed for total elimination.

I do not see that this is a good choice for allocation of health care resources. I would be interested if there is some policy reason why you do not favor these urban Indian health programs, or is there something else going on here?

Secretary LEAVITT. Senator, as you know, the Indian Health Service is a part of this Department. I will tell you, from my observation, they are the most compassionate people on the planet. They are wonderful, working hard to serve the needs of those in the Native American community.

I mentioned earlier there were a series of principles that I had framed up for the Department to say, when you look at investments, let us look at them. One of them is, let us look across the Department. Instead of just having siloed investments, let us look across the Department and find ways to create efficiencies so that we are not just looking at investment in Indian Health, but we are looking at the communities as well.

This is a prime example. I looked at the fact that we were building a network of community health centers in cities like Albuquerque and other places around the country, and we also had Indian Health Service clinics, and in some cases they were in reasonable proximity to one another, and probably neither of them was adequate to serve the populations.

But if we had one, it could be in a situation where you would have one piece of equipment instead of two, one lease instead of two. They were essentially serving the same population. It just did not make sense to me not to proceed forward on some consolidation of that mission.

Senator BINGAMAN. So the idea is that the Native American who had been going to the Albuquerque Indian Health Center would go to community health centers?

Secretary LEAVITT. That is right.

Senator BINGAMAN. Now, as I understand it, I visited this Indian Health Center. It is essentially geared up to do hospital-type health care. I have never been in a community health center that was geared up for that kind of thing. Is it your thought that they are doing the work at these community health centers that will essentially substitute for what is going on at the Indian Health Center?

Secretary LEAVITT. That just feels inefficient to me to be creating a separate system for one population of people when we are trying to create a much better system for everyone. If we are building a separate set of facilities for the Native American population who live in urban areas than we are for the larger population, neither——

Senator BINGAMAN. So it is a policy judgment that we should not have an urban Indian program? Indians, if they want to move to the city, ought to go to the regular community health centers?

Secretary LEAVITT. It is a policy judgment that we ought to serve people in the best possible way we can, and having duplicate facilities does not serve people, or taxpayers, well.

Senator BINGAMAN. All right.

Let me ask about Medicaid. As I read your budget, the net effect of your proposal over the 5 years is a $13.5 billion cut in Medicaid. I am told that 59 percent—this is an estimate by the Center on Budget and Policy Priorities—is from shifting cost to the States. Fifty-nine percent of what you are proposing that we legislate would involve shifting cost to the States. Ninety-six percent of what you are proposing to do in a regulatory way would involve shifting costs to the State.

I just wonder. I think you said in your earlier comments before I arrived that the States are under more and more difficulty trying to cover the cost of Medicaid. Why does it make sense for us to say we are going to load onto that problem some additional problems?

Secretary LEAVITT. Senator, first let me say that I believe if we were to sort through the policy impact of the proposals we are making today, that there would be disagreement on our parts as to whether or not we were shifting it to the States.

But let us leave that one for a second and just say that my biggest concern is that neither the States nor the Federal Government can sustain Medicaid in its current form. We made some important steps forward in the Deficit Reduction Act. These are efficiencies that we believe can help us create a sustainable program.

I want to emphasize that Medicaid will continue to grow. There is no cut here. It will continue to grow at a rate well in advance of 7 percent a year. The reason that I made the comments earlier was it is clear to me that it is not only unsustainable from the national government standpoint, but it is unsustainable for States as well.

Senator BINGAMAN. All right. I think my time is up, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator BINGAMAN. Thank you.

The CHAIRMAN. We will start a second round of 5 minutes each.

I want to cite a statistic here that my staff has collected in regard to HSAs, those people that have bought HSAs for the first time. Thirty-seven percent of them were previously uninsured.

Treasury estimates that the President's proposal will increase the number of HSAs from 14 million in 2010 to 21 million in that same year, 2010. That would be a 50 percent increase.

Therefore, if the trends continue, about 8 million uninsured would opt in to coverage with HSAs. I presume that is based on that 37 percent.

I want to talk about SCHIP. My State of Iowa, along with other States, is going to have a shortfall in this program providing health insurance coverage for low-income people.

While we included funding in the Deficit Reduction Act to address this year's shortfall, I am informed that shortfalls are still going to persist, at least through next year.

Now, I know you share my concern about the value of this program. It is unfortunate that we face a reauthorization of SCHIP so that States are not put in a position of eliminating coverage for low-income people. The President's budget proposes to address State shortfalls. Could you elaborate on the proposal to address those shortfalls?

Secretary LEAVITT. Yes. Let me address, then, both of those. First, with respect to health savings accounts, your statistics are square with mine. I met a man recently who had started an organization that now serves 150,000 customers. It was a bank that administers them.

He made very clear to me, nearly 40 percent of the people who have these did not have insurance before. Demographically, he points out that 40 percent of them are people who make under $50,000 a year in income.

A majority of the purchasers are families that have children. Half of the purchasers are over the age of 40. Americans with HSAs have no better health status than those with traditional coverage.

What this is doing is putting insurance within the reach of a large population of people who are currently losing their hope that they can have insurance. We are also seeing a number of businesses and other organizations that provide health care that are finding themselves unable to do so. This is a very important part of being able to keep health care within the reach of the average American.

Now, another important part of that is SCHIP. You raised that point. It is clear that has been a program that we both admire and see the advantage of. There have been States which have had needs that have gone beyond their appropriation or our authorization, and you have fixed that in the short term. There will be an ongoing need to do that in the long term.

The CHAIRMAN. We included $750 million—and that's a 5-year figure—for grants for programs to promote healthy marriage and responsible fatherhood.

That is a substantial amount of money that I think is a good investment, because, in strengthening marriage and fatherhood, it is

without a doubt one big step towards reducing, or keeping people out of, poverty and enhancing child well-being.

I assume you concur in that. But how do you intend to ensure that these funds are appropriately spent and will result in the desired outcomes? The reason I asked that question is because there are a lot of people in Congress who are not too enthusiastic about that program. I like it, but some do not. So, we have to make sure we have our eye on the ball as that money is spent.

Secretary LEAVITT. Mr. Chairman, the impetus for a great deal of this came from the States. Prior to my service on the President's Cabinet, I served as Governor. I know with certainty that Governors who deal with the problem of marriages that do not function are deeply concerned and desirous of being able to exercise the principle that I spoke of earlier, which is prevention.

This is an effort to prevent before we have to treat. It is a far more efficient and humane way to do it, and it is the only way we will ultimately get to the bottom of it. It will be the States who ultimately use these dollars to find many ways to efficiently use it.

That has been true of all of the Human Service programs. When we have allocated dollars and put significant guidelines to guide them, the States have found ways to use it. I am already seeing States advance ideas on how to do it.

This is a difficult subject. The reason that people occasionally feel uncomfortable with it is because marriage is not always the easiest subject to discuss. But it is clearly at the heart.

It is undeniable that those families, those children who are able to be in a successful family where marriage is part of it, are more successful. We need to encourage that as a social institution.

The CHAIRMAN. Yes. Thank you.

Now, Senator Baucus?

Senator BAUCUS. I will be brief, Mr. Chairman. Thank you very much.

The CHAIRMAN. And then Senator Lincoln, then Senator Bingaman.

Senator BAUCUS. Mr. Secretary, I earlier asked you some basic national questions. I would like to turn to my State of Montana for my couple, three. I will make three points and you can address them. I will give you all them at once, first.

First is, I very much appreciate your deep interest in Libby, MT. It means a lot to me, and especially the folks in Libby.

As you may know, there is a clinic up there called the CARD Clinic. It is a center for asbestos-related diseases and it provides health care and screening. Regrettably, it has run out of money. It has three more months left. Also, regrettably, the company, W.R. Grace, is backing off on health care payments to people.

So I just ask you to take a good, hard look at that CARD Clinic and see if you can get some dollars up there to help those people who, as you well know, need a lot of help because of asbestos.

Second, I see the budget proposes eliminating the $33 million Urban Indian Health Program. As you know, about 60 percent of Native American Indians do not live on a reservation, they live in cities. I wonder if perhaps you have some other way of addressing their health care needs to help take care of them.

Third, anything you can do in your budget—I know a lot of this is other budgets—to fight methamphetamine. It is a huge problem nationwide. You know that as well as anybody here. We would like to have some real focused meth grants.

Montana is in the top quartile of States for methamphetamine abuse. I think we are one of the top 12, or something like that, because we are just in a wide open space and it is easy to build labs and for meth to come in from Mexico, Canada, and so forth. So, I very much hope that you can look at those three.

The CHAIRMAN. Let me associate myself with those remarks because my next question, which I will not have to ask now, was going to be on methamphetamine, along the same lines of what Senator Baucus said.

Secretary LEAVITT. Let me start with that one then and work my way back. Senator, I am fascinated by what is happening in Montana with private foundations stepping up to see if they can—Tom Siebold put a lot of money into a foundation that is driving an effort to deal with the demand issue.

I personally believe that that is ultimately what we have to do, is focus on the demand side of this, as well as supply. But until we start getting demand down, people are going to find a way to get it in, whether it is from Mexico or some kind of lab.

Senator BAUCUS. Well, let us hope not. But you might be right.

Secretary LEAVITT. That is right. Well, I would like very much to think that is not true, but history has demonstrated that, until we get demand down, they find a way.

The second point on urban health: Senator Bingaman and I had a conversation while you were out of the room. But let me repeat, briefly, that we are increasing the amount of money we are putting into the Indian Health Service in the rural areas, but we are making a policy judgment that we are better off, rather than building community health centers and urban Indian Health Centers in the same communities, building the community health center into something that meets our aspirations, and to serve the urban Indian population through those, for reasons that I can enumerate again if you would like. That is the policy judgment we have made in our budget, and I feel good about it.

With respect to Libby, I visited once at your invitation.

Senator BAUCUS. Thank you.

Secretary LEAVITT. We have been trying to get together on a second visit so I can actually see the clinic.

Senator BAUCUS. Right.

Secretary LEAVITT. It was a very helpful thing for me to do so, and I hope that occasion will occur.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Mr. Secretary, as a daughter, I know how proud you are to have your dad here. Now as a parent myself, I know how proud your father is to be here, supporting you.

My last two questions actually reflect back on my own father, whom I lost several years ago after a very long journey with Alzheimer's.

In looking at the priorities of the President's budget, not just this year but certainly in years past, I'm concerned about the elimination of a program, which is the program with geriatric training at all levels through support for geriatric education centers, fellowship programs, and small grants to junior facilities for career development.

Just as we anticipated there would be very difficult situations in the transition of dual-eligibles on the Medicare prescription drug component and sought to try to alleviate those problems before they happened, we know a lot of baby boomers are aging and we know that our population is aging.

With 126 medical schools and only 3 of those having a department in geriatrics, these types of programs are critically important. This program is gone. You all recommended eliminating it last year. We saved it for one more year 2 years ago, and it is now gone.

And certainly the elimination of programs like this runs counter to the recommendation from the recent White House Conference on Aging, where increased funding for geriatric training ranked in the Top 10 list of recommendations.

Certainly for most medical institutions, but I think really all, without Federal funding to support geriatric education for our health care professionals, the workforce that we are going to need in the future will be deprived of this vital aspect of their training, and we are going to be deprived of being able to care for our growing elderly population.

My first question to you is, what are you as an administration recommending to take care of that? I know that for us in rural America, but I think for all people across the Nation, finding health care for aging parents, particularly those with Alzheimer's, is getting increasingly more difficult. These individuals are not being trained.

We in Arkansas were able to train, since 2000, through the Arkansas Geriatric Education Center, about 10,000 health professionals. We will no longer be able to do that, more than likely, with the elimination of this program.

Also to that end, in terms of end-of-life care, the President proposed a cut in the hospice payments, which would cost Arkansas providers approximately $5.1 million in hospice payments over 5 years.

I do not know about others' experience, but I know that with hospice it was an incredible support system for our family and it enabled us to really fulfill my father's wishes, which were to be at home in his end-of-life situation.

Most experts agree that this is an under-utilized benefit. I am afraid that the cut will further exacerbate that problem.

The other thing is, the hospice payment cut was not recommended by MEDPAC. I think if you talk to most individuals who have used hospice, you will realize that it is a valuable, valuable tool. If we eliminate that, as well as the training for elder care, then we are going to have a real problem in the years to come.

But suggestions you all have, what you are going to supplement those with?

Secretary LEAVITT. Senator, I do not know of anyone who has not been touched in a very personal way by this disease, a family member, a friend, whoever. It is a difficult, hard part of our mortal life.

I would just point to three things. First, we did make the decision not to re-fund the program. We did it for two reasons. One is, I am looking for ways I can actually pay for treatment, not just for infrastructure. In my mind, this fell under that category.

Senator LINCOLN. But what about those who administer treatment? If we do not train them, the treatment does not get there.

Secretary LEAVITT. The second conclusion I drew is, I was having a very hard time measuring the success of this program. I do not doubt the fact that it provides value, but in a budget year you have good things competing with good things. The way I made this decision was to say I cannot measure that, and I am not certain.

The third thing I will just point to is that we had to make decisions on whether we spend on one thing or another, and I concluded that I wanted to spend across the Department, as much as I could, on prevention.

So you will see in this budget a substantial initiative on genes and environment, because I think ultimately, if we are able to use that new level of knowledge that we have, we will find a way in which we can begin to prevent, or at least preempt, or in some way delay that terrible experience that people have.

Senator LINCOLN. I hope you are right on that. But I just worry about those who are suffering currently without the appropriate care. It is a tough way to go.

Secretary LEAVITT. It is very difficult.

Senator LINCOLN. Thank you.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you.

Let me ask about an issue I raised with Mark McClellan yesterday, and he said he would look into it. I would like to see if you could also look into it.

The Congress put a provision in the prescription drug bill, which was passed over 2 years ago now, that said that as to the Indian Health Service, when they contract for health services, they cannot be charged more than Medicare is charged.

We also said that, effective a little over a year ago, your Department was to issue a regulation to implement that. No regulation has been issued. It is costing millions of dollars to the Indian Health Service to continue paying what they are having to pay.

If you would issue that regulation, I believe it would save the Indian Health Service millions of dollars in their payments for these contract health services. I would ask you to look at that and try to get that regulation out, if you could.

Secretary LEAVITT. Thank you. I was in Santa Fe on Friday, meeting with Governor Richardson on the ways to work through any New Mexico-specific problems on Part D, and he raised this subject.

Senator BINGAMAN. Very good.

Secretary LEAVITT. I talked with both our regional people and Governor Richardson and his Medicaid colleagues. We concluded that I would, in fact, go back and review it. We are in the process

of doing so. When we reach a conclusion, I would be very pleased to communicate that with you.

Senator BINGAMAN. Well, I would appreciate that. It is a priority for me, and I am sure it is for our Governor as well.

Go back just a minute to this urban Indian health issue, bringing this down to a concrete circumstance we have there in Albuquerque. First Choice is the name of the provider that runs our community health centers. We have a couple there in Albuquerque.

I have been there to visit those centers, and they have people waiting in line for services. If in fact we are going to terminate funding for the Indian Health Center on the theory that the 30,000 Native Americans who have been getting their health services there can go to these other centers, it would seem that we ought to be putting some resources in to building additional community health centers, expanding the existing ones, doing something in that community. Is that being done?

Secretary LEAVITT. Let me deal with it globally and then speak directly. We do have, in this budget, the capacity to expand or add 302 new community health centers; 80 of those will be targeted to the most impoverished areas or counties.

I do not know specifically whether or not Albuquerque will be on that list because it will require them to make application.

Now, what you have described for me seems absolutely logical. If we are going to follow this policy, then we have to create capacity, or at least find ways—and it is possible as well that it could come out of these new dollars, if they apply.

I would be very pleased to make certain that we have regional people who are looking at that to determine how to affect it. I am dealing at the policy level, but that is a very compelling specific and one that we ought to look into.

Senator BINGAMAN. Thank you very much. I would appreciate it if you can look into that and get back to us.

The Chairman mentioned that I think the figure was 37 percent of the people who have, I believe he said, purchased HSA policies——

The CHAIRMAN. Since we passed the law, 37 percent have not had health insurance previously.

Senator BINGAMAN. Right.

The CHAIRMAN. So it subtracts from the pool of uninsured.

Senator BINGAMAN. Right. My understanding of how this HSA thing works is, you have to do three things to really get the benefits. You have to, first of all, buy the policy, a high-deductible policy which says that you, the individual, are responsible for the first $1,000, $2,000, or whatever the figure is. It has to be at least $1,000. So, you are taking that responsibility. So you buy the policy.

Second, you establish the HSA, because you do not have to establish an HSA just because you bought the policy. Then the third thing you have to do is, you have to put money in the HSA so that there is something there to pay for health care costs. I mean, otherwise you do not get any benefit from having the HSA.

Do we have statistics, first of all, on how many people who have purchased these high-deductible policies have actually gone and established a health savings account? Second, how many of those who

have established a health savings account have actually put money into it so they can pay for their health care costs?

Secretary LEAVITT. Let me address that on several levels. There are a lot of people in America who do not have health insurance, not because it is not available to them, but because they just choose not to buy it.

Senator BINGAMAN. Right.

Secretary LEAVITT. In many cases, they choose not to buy it because they think it is too expensive. When they think it is too expensive, implicit in that decision is, I do not think I am ever going to need it, therefore I am not going to buy it. A lot more of them would do it if they thought it was $200 a month instead of $500 a month. Society would be dramatically better off if everyone had at least a high-deductible plan.

Senator BINGAMAN. So catastrophic coverage would be a good thing.

Secretary LEAVITT. It would be a very good thing.

Senator BINGAMAN. Right. For the whole country. Right.

Secretary LEAVITT. And one of the problems now is, if you buy an HSA through a non-employer, if you buy it as an individual, you are not treated in the same way tax-wise that you are if you get it through your employer. So, this is one way to encourage people to buy insurance.

The second point is, as you know, if a family were going to pay $900 a month for a full indemnity plan and they could buy a high-deductible plan for $500, that $400, in most cases—in fact, almost every case I know of—goes into some account that the employer puts in for the employee. Therefore, they have dollars that are available to them to pay the first dollars.

Senator BINGAMAN. But that is in a circumstance where they have had insurance before. I am asking about the group that Senator Grassley was referring to, which are people who have not had any coverage.

Their employers have never provided them with coverage. All of a sudden, they do have a high-deductible policy. How many of them have money in an account so that they can actually pay for their health care costs?

The CHAIRMAN. I think you said it right, except do not assume with that 37 percent. Some of them could have been at an employer where they had health insurance and just decided not to participate in it. Those people would be part of the uninsured as well.

Senator BINGAMAN. Right. Right.

The CHAIRMAN. Go ahead.

Senator BINGAMAN. But my concern is, I saw an article in the *Wall Street Journal* or somewhere which said something over 60 percent of the people who have bought the policies have not put any money into these accounts. I do not know if that is the right statistic. But I wonder, do you have those statistics? Could you get that to us?

Secretary LEAVITT. I do not have them today, but if they are available I would be pleased to both have them and to share them with you.

The CHAIRMAN. And I would like to have them, too.

Secretary LEAVITT. I can tell you that I have spoken with those who administer these accounts and they assure me—in fact, they talk to me about the average balance on their accounts and how they come down toward the end of the year. The vast majority of people who buy them are finding the advantage. I cannot give you actual statistics, but I will get them.

Senator BINGAMAN. I think my concern is that there are a lot of people who may buy the high-deductible policies for whom there is no account to administer because they have not put any money in it.

Secretary LEAVITT. But there are several aspects of the President's proposal, one of which is to even out the tax treatment. Whether or not it is with an HSA or not, we have every advantage, in my judgment, this year to see incentives created for people to buy insurance.

They are a lot better off, and society is a lot better off, if they have catastrophic coverage than if they do not, and that is one part. I will do my best to get information.

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

The CHAIRMAN. Thank you.

The hearing is completed. I thank you, Mr. Secretary, and ask any members who have questions in writing, that those would be submitted to us by close of business Monday night. Thank you, Mr. Secretary.

[Whereupon, at 11:38 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Opening Statement of Sen. Chuck Grassley, Chairman
Senate Finance Committee
Budget Hearing with Secretary Michael Leavitt
Thursday, February 9, 2005

On Monday, February 6, President Bush released his proposed budget for Fiscal Year 2007. Today, it is my pleasure to welcome Secretary Michael Leavitt who will discuss the President's spending proposals related to Medicare and Medicaid. The Committee has a great interest in the Administration's priorities for the Department of Health and Human Services. This hearing will provide the Committee an opportunity to further discuss the details of the President's budget. Specifically, the President's budget proposes substantial savings in the Medicare program and additional reforms to Medicaid. Together, these provisions would decrease spending by almost $50 billion over the next five years.

Just yesterday, the President signed it into law the Deficit Reduction Act. This legislation will reduce the growth in Medicare and Medicaid spending by $11.1 billion over five years. This reduction is relatively modest – representing just one-fourth of one percent of what Congress would otherwise be spending on these programs during this period. However, it is nevertheless a significant accomplishment. It has been eight years since Congress last passed legislation that reduced mandatory spending. And, as you know, this achievement was not easy. I don't think I am going to shock anyone by saying that any more reductions of a significant scope could be difficult to achieve this year. The DRA will reduce Medicare spending by $6.4 billion over five years. Some of the key provisions here included changing how Medicare pays for imaging services, durable medical equipment and oxygen.

The legislation also provides incentives for hospitals and home health agencies to report quality data. And, for the first time ever, Medicare will reduce payments to hospitals if patients acquire a preventable infection during their hospital stay. In Medicaid, the DRA responded to calls by America's bipartisan governors for new tools to help them improve services and control costs in the program. The result – $6.9 billion in savings over five years.

The DRA will ensure that states accurately pay for prescription drugs. That elder law attorneys no longer exploit loopholes to get people with means onto Medicaid. That states can appropriately use cost-sharing to control utilizations. And, that health beneficiaries are not locked into a one-size fits all benefit but receive a benefit more like private insurance.

Finally, the DRA spends $11 billion over 10 years to expand coverage for populations in need through the Family Opportunity Act, Money Follows the Person, expanded Home and Community Based Services and the Cash and Counseling Program.

It's especially rewarding to have included in the DRA a bill I first authored in 1999, the Family Opportunity Act, which I've pushed for year after year with Sen. Kennedy. It was inspired by an Iowa family struggling to access health care services for a disabled child. Melissa Arnold, the mother, didn't give up, and today's legislative victory is a tribute to her kind of determination. The measure will let states create options for families who have children with multiple medical needs to buy into Medicaid while continuing to work.

Now, back to this year. One area we will probably need to address this year is physician payments. The physician payment formula is still flawed. While the DRA provided a one-year, zero percent update to physician payments, doctors are scheduled for a 4.6 percent reduction in payments for 2007. And, there is conflicting news about hospitals. Hospitals, on average, are losing money treating Medicare patients. Yet, at the same time, USA Today reports that hospitals have their highest overall margins ever.

And all hospitals are not the same. Apparently, teaching hospitals are making a 6% profit on Medicare patients, while non-teaching hospitals are losing 6% treating beneficiaries. There is a problem here. I am sending a letter today to urge CMS to make changes that should improve the accuracy and equity of the hospital inpatient payment system. I think an across-the-board reduction – and in some cases a freeze – to provider payments will be challenging. There may be other ways to achieve the same goal. One area where we need to do more is in rewarding quality. As you know, I fully support efforts to link provider payment to quality. I see from the budget that the Administration supports differential updates to encourage physicians to report quality measures – something I also support. But frankly, I was a bit disappointed that the Administration is not proposing bolder steps in this area. We need to engage all providers – including physicians, nursing homes, and health plans.

The reporting of quality data is a good first step toward increased transparency. Just the reporting of quality data has resulted in improvements in quality for hospitals. And, I believe that consumers need access to quality and cost information on providers so that they can become more engaged in their health care decisions. We need more transparency on health costs because beneficiaries don't know what they are paying for. Data on providers' costs and quality should be publicly available to give consumers an idea of what they're buying.

Giving consumers more direct involvement in paying for their care will prompt them to shop for the best value, ultimately choosing the highest-quality and lowest-cost care. This will increase competition, resulting in improvements throughout the health care system. If Medicare reductions do end up on the table, the Medicare Advantage regional stabilization fund should be at the top of the list. This fund hasn't been used at all. There are already a good number of regional Medicare Advantage plans participating. It is clear that this fund is not needed.

The President's Budget calls for continued reform to the Medicaid and State Children's Health Insurance Program (SCHIP) programs. As I mentioned earlier, the DRA made significant changes to these programs. These changes were what governors across the county – Republican and Democrat – asked for to help keep Medicaid programs afloat for the millions of people who rely on Medicaid. I look forward to working with the Administration on implementing the provisions in the DRA.

The FY 07 Budget includes some Medicaid expansion programs. I support extending Transitional Medical Assistance for those families working their way off welfare and the Administration's "Cover the Kids" campaign. Additionally, I look forward to working with the Administration in addressing the upcoming shortfalls in the State Children's Health Insurance Program. I also look forward to hearing more about the President's proposals on the uninsured. There are now almost 46 million Americans without health care. We need new strategies to solve this persistent problem. Continued expansion of health savings accounts, coupled with tax deductions and credits to encourage their use, is a good step forward. I hope we can put partisan politics aside here and have a thoughtful debate on this critical issue. We must make changes to contain health care costs and help reduce the number of uninsured in this Country.

And, beneficiaries and taxpayers both deserve to get the highest value for ever dollar that's spent on Medicare, Medicaid and other safety net programs. The President's budget always sets off a good debate on Capitol Hill. Mr. Secretary, thank you again for being here today and for sharing more detail on the President's proposals.

Testimony
Before the Committee on Finance
United States Senate

The President's FY 2007 Budget Request for the Department of Health and Human Services

Statement of
Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 am
Thursday, February 9, 2006

Good morning, Mr. Chairman, Senator Baucus, and Members of the Committee. I am honored to be here today to present to you the President's FY 2007 budget for the Department of Health and Human Services (HHS).

Over the past five years, the Department of Health and Human Services has worked to make America healthier and safer. Today, we look forward to building on that record of achievement. For that is what budgets are — investments in the future. The President and I are setting out a hopeful agenda for the upcoming fiscal year, one that strengthens America against potential threats, heeds the call of compassion, follows wise fiscal stewardship and advances our Nation's health.

In his January 31st State of the Union Address, the President stressed that keeping America competitive requires us to be good stewards of tax dollars. I believe that the President's FY 2007 budget takes important strides forward on national priorities while keeping us on track to cut the deficit in half by 2009. It protects the health of Americans against the threats of both bioterrorism and a possible influenza pandemic; provides care for those most in need; protects life, family and human dignity; enhances the long-term health of our citizens; and improves the human condition around the world. I would like to quickly highlight some key points of this budget.

We are proposing new initiatives, such as expanded Health Information Technology and domestic HIV/AIDS testing and treatment that hold the promise

for improving health care for all Americans. We are continuing funding for high-performing Presidential initiatives, including Health Centers, Access to Recovery, bioterrorism and pandemic influenza; and we are also maintaining effective programs such as Indian Health Services, Head Start, and NIH medical research.

We are a nation at war. That must not be forgotten. We have seen the harm that can be caused by a single anthrax-laced letter and we must be ready to respond to a similar emergency — or something even worse. To this end, the President's budget calls for a four percent increase in bioterrorism spending in FY 2007. That will bring the total budget up to $4.4 billion, an increase of $178 million over last year's level.

This increase will enable us to accomplish a number of important tasks. We will improve our medical surge capacity; increase the medicines and supplies in the Strategic National Stockpile; support a mass casualty care initiative; and promote the advanced development of biodefense countermeasures through NIH to a stage of development so they can be considered for procurement under Project BioShield.

We must also continue to prepare against a possible pandemic influenza outbreak. This budget includes a $2.3 billion allowance for the second year of the President's Pandemic Influenza plan. These funds will enable us to meet several important goals, including providing pandemic influenza vaccine to every

man, woman and child within six months of detection of sustained human-to-human transmission of a bird flu virus; ensuring access to enough antiviral treatment courses sufficient for 25 percent of the U.S. population; and enhancing Federal, state and local as well as international public health infrastructure and preparedness.

The President's FY 2007 budget also provides more than $350 million for important ongoing pandemic influenza activities such as safeguarding the Nation's food supply (FDA), global disease surveillance (CDC), and accelerating the development of vaccines, drugs and diagnostics (NIH).

The budget includes a new initiative of $188 million to fight HIV/AIDS. These funds support the objective of testing for three million additional Americans for HIV/AIDS and providing treatment for those people who are on state waiting lists for AIDS medicine. This initiative will enhance ongoing efforts through HHS that total $16.7 billion for HIV/AIDS research, prevention, and treatment this year.

The budget maintains the President's commitment to the doubling of NIH, and includes important cross-cutting initiatives that will move us forward in our battle to treat and prevent disease – $49 million for the Genes, Environment and Health Initiative and $113 million for the Director's Roadmap. In addition, it contains an additional $10 million for the Food and Drug Administration to lead the way forward in the area of personalized medicine and improved drug safety.

One of the most important themes in our budget is that it increases funding for initiatives that are designed to enhance the health of Americans for a long time to come. For instance, the President's budget calls for an increase of nearly $60 million in the Health Information Technology Initiative. Among other things, these funds support the development of electronic health records (to help meet President Bush's goal for most Americans to have interoperable electronic health records by 2014); consumer empowerment; chronic care management; and Biosurveillance.

The Budget also includes several initiatives to protect life, family and human dignity. These include, for example, $100 million in competitive matching grants to States for family formation and healthy marriage activities in TANF. And it promotes independence and choice for individuals through vouchers that increase access to substance abuse treatment.

In the area of entitlements programs, I want to begin by congratulating you and other Members of Congress for having successfully enacted many needed reforms by passing the Deficit Reduction Act (DRA). DRA supports our commitment to sustainable growth rates in our important Medicare and Medicaid programs. It also strengthens the Child Support Enforcement program. The Deficit Reduction Act also achieves the notable accomplishment of reauthorizing Temporary Assistance for Needy Families (TANF), which has

operated under a series of short-term extensions since the program expired in September 2002.

Medicaid has a compassionate goal to which we are committed. Part of our obligation to the beneficiaries of this program is ensuring it remains available well into the future to provide the high-quality care they deserve. Last year when I made my statement before this Committee, I said that the growth in Medicaid spending is unsustainable. With its action on many of our proposals from last year in the Deficit Reduction Act, the Congress has made Medicaid a more sustainable program while improving care for beneficiaries. The President's Budget proposals build on the DRA and include a modest number of legislative proposals which improve care and will save $1.5 billion over five years in Medicaid and S-CHIP and several administrative proposals saving $12.2 billion over five years.

This Administration has also pursued a steady course toward Medicare modernization. In just the past three years, we have brought Medicare into the 21st century by adding a prescription drug benefit and offering beneficiaries more health plan choices.

Medicare's new prescription drug benefit provides seniors and people with disabilities with comprehensive prescription drug coverage, the most significant improvement to senior health care in 40 years. Millions of seniors and people

with disabilities are already using this benefit to save money, stay healthy, and gain peace of mind. According to CMS' Office of the Actuary, Medicare's drug coverage will have significantly lower premiums and lower costs to federal taxpayers and states, as a result of stronger than expected competition in the prescription drug market. Moreover, beneficiary premiums are now expected to average $25 a month – down from the $37 projected in last July's budget estimates. The Federal government is now projected to spend about 20 percent less per person in 2006 and, over the next five years, payments are projected to be more than ten percent lower than first estimated. So taxpayers will see significant savings. And state contributions for a portion of Medicare drug costs for beneficiaries who are in both Medicaid and Medicare will be about 25 percent lower over the next decade. All these savings result from lower expected costs per beneficiary; projected enrollment in the drug benefit has not changed significantly.

Our work to modernize Medicare is not done. Rapid growth in Medicare spending over the long-term will place a substantial burden on future budgets and the economy. The President's FY 2007 Budget includes a package of proposals that will save $36 billion over 5 years and continue Medicare's steady course toward financial security, higher quality, and greater efficiency.
Along with the sustainability of Medicaid, our budget takes steps to improve the long-term fiscal health of Medicare. We are proposing a number of adjustments that will produce a substantial savings.

The bulk of these Medicare savings will come from proposals to adjust yearly payment updates for providers in an effort to recognize and encourage greater productivity. These proposals are consistent with the most recent recommendations of the Medicare Payment Advisory Commission. To ensure more appropriate Medicare payments, the Budget proposes changes to wheelchair and oxygen reimbursement, phase-out of bad debt payments, enhancing Medicare Secondary Payer provisions, and expanding competitive bidding to laboratory services. Building on initial steps in the Medicare Modernization Act, the Budget proposes to broaden the application of reduced premium subsidies for higher income beneficiaries. Finally, the President's Budget proposes to strengthen the Medicare Modernization Act provision that requires Trustees to issue a warning if the share of Medicare funded by general revenue exceeds 45 percent. The Budget would add a failsafe mechanism to protect Medicare's finances in the event that action is not taken to address the Trustees' warning. If legislation to address the Trustees' warning is not enacted, the Budget proposes to require automatic across-the-board cuts in Medicare payments. The Administration's proposal would ensure that action is taken to improve Medicare's sustainability.

President Bush proposes total outlays of nearly $700 billion for Health and Human Services. That is an increase of more than $58 billion from 2006, or more than 9.1 percent.

While overall spending will increase, HHS will also make its contribution to keeping America competitive. To meet the President's goal of cutting the deficit in half by 2009, we are decreasing HHS discretionary spending by about $1.5 billion in the next fiscal year.

I recognize that every program is important to someone. But we had to make hard choices about well-intentioned programs. I understand that reasonable people can come to different conclusions about which programs are essential and which ones are not. That has been true with every budget I've ever been involved with. It remains true today. There is a tendency to assume that any reduction reflects a lack of caring. But cutting a program does not imply an absence of compassion. When there are fewer resources available, someone has to decide that it is better to do one thing rather than another, or to put more resources toward one goal instead of another.

Government is very good at working toward some goals, but it is less efficient at pursuing others. Our budget reflects the areas that have the highest pay-off potential.

To meet our goals, we have reduced or eliminated funding for programs whose purposes are duplicative of those addressed in other agencies. One example of this is Rural Health where we have proposed to reduce this program in the

Health Resources and Services Administration, given that HHS administers 225 health and social services programs that provide resources to rural areas. In addition, the Medicare Modernization Act contained several provisions to support rural health, including increased spending in rural America by $25 billion over ten years. For example, it increases Medicare Critical Access Hospitals (CAH) payments to 101 percent of costs and broadens eligibility criteria for CAHs. Moreover, recognizing that Congress adopted many of our saving proposals last year, we are continuing to make performance-based reductions.

Our programs can work even more effectively than they do today. We expect to be held accountable for spending the taxpayers' money more efficiently and effectively every year. To assist you, the Administration launched ExpectMore.gov, a website that provides candid information about programs that are successful and programs that fall short, and in both situations, what they are doing to improve their performance next year. I encourage the Members of this Committee and those interested in our programs to visit ExpectMore.gov, see how we are doing, and hold us accountable for improving.

President Bush and I believe that America's best days are still before her. We are confident that we can continue to help Americans become healthier and more hopeful, live longer and better lives. Our FY 2007 budget is forward-looking and reflects that hopeful outlook.

Thank you for the opportunity to testify. I will be happy to answer your questions.

Finance Committee Hearing
"The President's Fiscal Year 2007 Budget Proposal"
Questions Submitted for the Record
Secretary Leavitt
February 14, 2006

Senator Grassley

1.
Question:
Mr. Secretary, there has been a great deal of misinformation circulating about certain provisions in the Deficit Reduction Act. I refer specifically to the provision that would allow states to enroll healthy individuals in a benchmark plan, but would guarantee that all children enrolled in Medicaid have the Early Periodic Screening, Diagnostic and Testing (EPSDT) benefit.

The conferees clearly agreed that EPSDT would be a guaranteed benefit. Can you provide this committee with assurances that you would not approve a state plan amendment that undermined this agreement?

Another misconception has occurred relative to a certain provision relating to a provision that enables states to require modest cost-sharing from certain Medicaid eligible individuals. The conferees clearly agreed that cost sharing would not apply to individuals below the federal poverty level. Can you provide this committee with assurances that you would not approve a state plan amendment that undermined this agreement?

Answer:
Children under 19 will still be entitled to receive EPSDT benefits under the new section 1937 of the Social Security Act. CMS will review each State plan amendment submitted under the new section 1937 and will not approve any State plan amendment that does not include the provision of EPSDT services for children under 19 as defined in section 1905(r) of the Social Security Act.

Second, the DRA permits states to establish modest cost-sharing for Medicaid beneficiaries between 100 and 150% FPL. Premiums are not permitted for this group of beneficiaries. Excluded from cost-sharing are:

- services furnished to individuals under 18 with mandatory coverage;
- preventive services for individuals under 18, regardless of income;
- services related to pregnancy or any other medical condition which may complicate the pregnancy for pregnant women;
- services for terminally ill individuals receiving hospice care, services for inpatients of a hospital, nursing facility, ICF/MR, or other medical institution who as a condition of eligibility are required to apply most of their income to the cost of care;
- emergency services;
- family planning services and supplies; and,
- services for women in the breast or cervical cancer program.

The DRA did not change current law with respect to copayments that could be imposed on beneficiaries under 100% of poverty. Under section 1916, nominal cost sharing can be applied to certain beneficiaries under 100% FPL.

2.
Question:
I see that the President's budget includes $169 million to promote nationwide interoperability of health IT systems and further develop best practices for the use of coordinating electronic health records in different settings. How will the proposed funding help speed the development of national standards for health IT?

Answer:
The FY 2007 budget request includes a total of $116 million for the Office of the National Coordinator for Health Information Technology (ONC). In addition to funds requested within ONC, the FY 2007 request includes $50 million in the Agency for Healthcare Research and Quality to advance the use of health IT to enhance patient safety. There is also $4 million in the Office of the Assistant Secretary for Planning and Evaluation for independent evaluations of EHR adoption and economic factors influencing health IT implementations in the health sector.

ONC will continue to build upon foundational initiatives underway through its contractors to develop the long-term capacity to support widespread adoption of interoperable health IT. Core activities include:

- Developing and harmonizing standards that are required for health information data portability, which will include a process to maintain and update these standards over time;
- Continuing the development of a certification process for health IT, which will include refinements to existing certification criteria for inpatient and ambulatory EHRs as well as new criteria related to the NHIN architecture.
- Continuing the development of production-quality prototypes for Nationwide Health Information Networks (NHINs) which will enable secure exchange of electronic health records (EHR) and other health data;
- Developing personal health record architectures that will be integrated with the NHIN architecture, which will allow personal health information data to be controlled by the consumer and not just by clinicians and providers;
- Evaluating variations in State laws and organization-level business policies around privacy and security practices, including variations in implementations of HIPAA privacy and security requirements. Lessons will be incorporated into the NHIN prototypes.

2. (part 2)
Question:
How do you see health care technology tying into the broader goal of paying providers based on their performance?

Answer:
In order to pay providers on the basis of their performance, we have to be able to measure that performance adequately. We have considered several different types of measures – measures of provider structure, measures of the processes of care providers use, and measures of the outcomes of their activities – each of which has advantages and drawbacks. While our plans are still evolving in this area, we are considering initiatives in which we would first pay providers for providing appropriate information about their activities, and then in subsequent periods provide incentive payments to those with better outcomes.

Based on the experience of the Hospital Quality Alliance, reporting quality measures has been demonstrated to improve the quality of hospital care. The hospitals participating in this program have not relied on electronic health records (EHRs) to collect data or report the measures, yet they have still achieved improvements in quality. As this initiative matures and EHRs become interoperable (i.e., can share data and report measures), physician offices will be in a better position to adopt health information technology (HIT) and EHRs to automate the reporting of quality measures. CMS is evaluating options to provide incentives for physician adoption of EHRs and has an ongoing initiative to support adoption and effective use of HIT through the Medicare Quality Improvement Organizations. As with other private sector initiatives (i.e., Bridges to Excellence), pay-for-performance can be successfully implemented in parallel with ongoing adoption and use of HIT. It is important to achieve interoperability and certification of EHRs prior to realizing widespread adoption of EHRs. Because certification will determine the minimum functional and interoperability requirements for EHRs, certified EHRs will provide a foundation for automated information collection of quality measures that can support pay-for-performance programs in the long term.

2. (part3)
Question:
What are your expectations for the adoption of health IT by physicians in rural areas once national standards are developed?

Answer:
Adoption of health IT by physicians in rural areas is part of a broader concern for health IT adoption in small physician practices in generally. Although low EHR adoption overall is a concern, there is a bigger concern with variable EHR adoption. Some clinicians are adopting EHRs more readily than others – creating an adoption gap based on the size of practice. This could prevent market forces and competition from improving healthcare. According to a study by the Commonwealth Fund, 57% of large group practices of 50 or more physicians are using an EHR, but only 13% of solo physicians are doing so. Larger practices have more resources, more ability to acquire information technology and more capacity to implement technology well. These characteristics for differential adoption rates are mirrored in rural vs. urban settings where the challenges are equally varied. These early adopters should be commended for their leadership, and they should not be faulted for their inventiveness. But, we need to develop solutions that assist EHR adoption up and down the spectrum of care delivery organizations.

Interoperability will help drive adoption of EHRs more quickly. With the advent of certified, interoperable EHRs and an interoperable NHIN, EHR adoption will be stimulated without subsidies by lowering the cost of technology and reducing risk to buyers. Clinicians will have greater price transparency when buyers can assess certified products and understand why one costs more than another. Further, health IT products will be more plug-and-play (i.e., requiring much less customization and integration work to get these systems up and running).

3.
Question:
Mr. Secretary, as you know I have expressed my concern about the rather broad interpretation of the Section 1115 waiver authority in the Social Security Act in many different contexts over the past several years.

I have continually maintained that any Administration should not circumvent the intent of Congress by approving substantial changes to current law through the waiver process.

However, in the past, I have been somewhat persuaded that as a result of Congress's inaction relative to reforms in the Medicaid that the only way states can cope with the strains on the Medicaid program is through the waiver process.

That all changed with the signing of the Deficit Reduction Act (DRA).

The DRA responded to many of the concerns raised by a bipartisan group of Governors and included many of the reform this same bipartisan groups requested. Therefore, the liberal use of the Section 1115 waiver authority, in my view, is unwarranted, at least in the near future.

Additionally, because the Congress will be holding hearings on the State Children's Health Insurance Program (SCHIP) this year and will be reauthorizing the program next year, extensive Section 1115 waivers for SCHIP are also unwarranted.

How do you view the implications of the Medicaid reforms in the DRA on the Section 1115 waiver process?

Answer:

I agree that the Deficit Reduction Act of 2005 (DRA) will reduce the need for waivers. In general, we will be encouraging states to use the flexibility of the DRA rather than the use of 1115 waivers.

I would like to emphasize that much of what was included in the DRA was based on the experiences of our partners, the states, who had implemented both Medicaid and SCHIP 1115 demonstration programs. Some of the most notable of these experiences involved new approaches to reforming and expanding options for long term care. Through both demonstrations and grants, states' experiences informed the policies that resulted in DRA provisions creating new state options and new funding for home and community-based care under the Medicaid State Plans. For instance, new optional services no longer require that beneficiaries receive institution-level care in order to take advantage of community services.

As you point out, the DRA also includes other important reforms that were supported by the National Governors' Association on a broad, bipartisan basis. Many of these reforms build on the success of the SCHIP model by enabling states to help more people get affordable coverage that meets their particular needs.

Again, these accomplishments are largely due to the lessons states learned from their experiences with demonstration and grant programs that were designed to meet specific goals unique to each state. This challenge continues as states look for new approaches to provide mainstream coverage to more people at a lower cost. We expect to continue to explore options through state demonstrations.

Recently approved and renewed demonstration projects in Florida, Rhode Island, Massachusetts and Utah have enabled these states to make affordable health coverage available to more people with a combination of mainstream health insurance, Medicaid and innovative delivery systems. These states have directed current health care dollars to provide expanded coverage, and worked with employers to ensure that employer-sponsored insurance not only remains available, but that more people have access to it. As of November 2005, over 800,000 individuals nationwide can get coverage through a HIFA demonstration, the streamlined 1115 demonstration process implemented by this Administration.

Other states continue to develop new approaches to tackling their growing health care budgets while attempting to cover more individuals. The 1115 demonstration authority provides states with the tools necessary to help them achieve these goals.

4.
Question:
Mr. Secretary, I am particularly concerned with two provisions in the President's budget that eliminated funding of the Community Services Block Grant and the proposal reducing funding for the Social Services Block Grant. I am a long time supporter of both of these programs. In fact, I have advocated that SSBG be increased to the FY 1995 level of $2.8 billion.

These programs are flexible sources of funding that states use to support a wide variety of social services. In my state of Iowa, SSBG funds are used to support services for persons with disabilities and provide child and adult protective services.

The Community Services Block Grant program also provides critical support to poor families throughout this country. CSBG supports service programs very important to my state such as the Low Income Home Energy Assistance Programs, literacy and job training, food pantries and meal programs, homeownership services, after-school programs and others.

I am curious as to the rationale for the elimination of the CSBG program and the reduction in funding for SSBG. Can you elaborate on the Administration's reasons for the reduction in funding for these important programs.

Does the Administration intend to continue to aggressively pursue changes to state Medicaid and SCHIP programs through the waiver process?

Answer:
A review by the Office of Management and Budget (OMB) in their Performance Assessment Rating Tool (PART) found that the Community Services Block Grant (CSBG) and the Social Services Block Grant (SSBG) lack clear goals and accountability measures, and cannot sufficiently demonstrate their impact on the nation's distressed communities.

Specifically, the CSBG program received a rating of Results Not Demonstrated in the PART evaluation. CSBG grants are passed through the States to be administered locally by Community Action Agencies (CAAs). The PART results indicate that CAAs receive funds through a non-competitive grandfathered system, and that CAAs are not held responsible for program results or outcomes. The FY 2007 budget proposes to eliminate the program in light of these key program weaknesses. In addition, key CSBG services targeting employment, housing, nutrition, and other health care duplicate services provided by other Federal programs.

The PART review also rated the SSBG program as Results Not Demonstrated since it lacks a national system of performance measures against which outcomes can be determined and improvements sought and lacks evaluation of sufficient scope for SSBG-funded activities and programs.

The program's flexibility and lack of State reporting requirements pose a challenge in developing measures. Therefore, we are working actively with the states to develop annual and long-term performance measures, and identify other accountability methods to ensure that funds are spent efficiently and effectively.

5.
Question:
Secretary Leavitt, government spending on health care services continues to grow. In 1980, the government spent $37 billion on Medicare. That figure is now over $300 billion.

I'm not sure there is an end in sight, given the increased costs of technology, the rise in chronic conditions such as diabetes and obesity, and the aging of the baby boomers.

The President's budget presents a number of legislative proposals to slow the rise in Medicare expenditures. Can you share with the Committee some of the steps that you have taken this past year, administratively, to control Medicare costs?

Answer:
Your statement is correct, and I would like to elaborate a little more because the cost of the Medicare program to taxpayers is one of my biggest concerns. The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 2004, Part A covered about 41 million enrollees with benefit payments of $167.6 billion, and Part B covered about 39 million enrollees with benefit payments of $135.4 billion. Administrative costs in 2004 were under 1.8 percent of disbursements for HI and under 2.1 percent of disbursements for SMI. Total disbursements for Medicare in 2004 were $308.9 billion.

National healthcare expenditures, including Medicare, are expected to grow over the coming decade due largely to the aging population and changes in medical technology and utilization. The Medicare program is projected to have a one-time overall spending increase of 25.2 percent in 2006 due to the new prescription drug benefit. This is significantly less growth than had been forecasted previously, however, as a result of new projections of the Medicare drug benefit's cost declining by 20 percent for fiscal year 2006. Overall Medicare growth is projected to slow to 5.4 percent in 2007.

As the baby boomers age into Medicare eligibility, we are seeing a steady increase in the number of beneficiaries. This increase in turn causes claims volume and costs to rise; we are now projecting that nearly 380 million fee-for-service claims will be processed in FY 2006, up from 341 million in 2003. Continued advances in medical technology are allowing people with Medicare to live longer, healthier lives. While some breakthrough technologies can have high costs, many promote greater efficiency in both

medical treatment and in health care administration and delivery. The Administration is committed to advancing and promoting the adoption of new technologies that can promote greater quality and efficiency in health care to help control spending increases in the years to come.

This year, the President's Budget proposes a number of administrative changes that would save more than $5 billion over the next five years. These proposals include improving payment accuracy with respect to long-term care hospitals, adjusting inpatient rehabilitation facility codes to more appropriately pay for services, exercising our inherent reasonableness authority to more appropriately pay for durable medical equipment and updating the coding for power mobility devices.

Last year, CMS implemented a number of Medicare administrative improvements to rationalize several components of Medicare's payment systems. For example, CMS improved payment accuracy for patients who are transferred from inpatient hospitals to post-discharge acute settings, such as nursing facilities, saving about $5 billion over five years. In addition, CMS refined the Skilled Nursing Facility Prospective Payment System in 2006 to ensure appropriate payments for certain high-cost cases. These improvements resulted in savings to the Federal government of approximately $4 billion over five years.

6.
Question:
The MMA requires higher-income beneficiaries, above a certain threshold, to pay a greater share of the Part B premium. These premium adjustments will be phased in over a 5 year period from 2007 through 2011. Starting in 2007, beneficiaries with an annual income over $80,000 and couples over $160,000 will have their premiums increased by a specified percentage. After 2007, the income thresholds will be annually adjusted for inflation.

The President's budget proposes to eliminate the annual inflation adjustments of the income thresholds for Part B income-related premiums. This would begin January 1, 2008.

If the thresholds are not annually indexed for inflation, but are held constant, how many beneficiaries are estimated to be affected by the higher income-related premiums (over 5 years and over 10 years)?

What is the percentage of beneficiaries that would be paying a higher premium under this proposal as compared to if the annual indexing for inflation were kept the same?

Answer:
Through provisions such as the income-related premium, the MMA began to rationalize and strengthen financing of the Medicare program as part of the effort to modernize the program and ensure its long-term viability. While Medicare will continue to subsidize the health care costs of the elderly and those with disabilities, the MMA began to limit the growth in these subsidies for higher-income beneficiaries in the future. This modernization gives those beneficiaries increased ownership of and greater responsibility for their health care needs while maintaining substantial subsidies for beneficiaries with more limited means. The President's Budget proposes to build upon the initial steps of the MMA and enhance implementation of this provision which promotes beneficiary ownership of health care choices. Under current law, in 2011, 1.7 million beneficiaries are affected by the income-related premium, and 1.9 million are affected in 2016. Under the FY2007 budget proposal, 2.3 million beneficiaries would be affected in 2011 and 3.8 million would be affected in 2016. If the budget proposal were enacted, fewer than 2 percent more beneficiaries would be affected by the provision in 2011 and fewer than 4 percent more would be affected in 2016.

7.
Question:
As you know, Senator Baucus and I introduced a bill last year that move towards paying providers for high quality and efficient care. After all, we would need to do everything we can to improve the quality of care and reduce costs. A concept that becomes even more important as health care costs continue to increase.

In the President's budget, the Administration supports physician payment reforms that do not increase taxpayer, Medicare or beneficiary costs, such as differential payment updates for physicians that report on quality measures and later for physicians that achieve efficient and high quality care.

As we all know, the physician payment formula is flawed. In fact, physicians are scheduled to receive close to a negative 5 percent cut in 2007. We also know that the cost to fix the formula permanently costs billions of dollars. How do you envision reforming the physician payment formula without increasing costs to the Medicare program, its beneficiaries, and the taxpayers?

What mechanism would CMS use to provide those physicians who report data with a different update?

Is CMS ready to implement a system that provides a different update to physicians who report quality measures?

Answer:
The current physician payment system focuses on payment for individual services, but does not provide incentives for physicians to take into account all of the services furnished to beneficiaries to treat an episode of care, or furnished during a period of time to treat chronic disease. This often has the effect of directing more resources to delivering care that is not of the highest quality (for example, duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications). Conversely, providers who have good ideas and want to take action to improve quality of care find that Medicare's physician payment system does not provide them with the resources or the flexibility needed to do so. As a result, providers are unable to invest in activities that, properly implemented, have the potential to improve quality and avoid unnecessary medical costs.

Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that result in improvements in the value of care that our beneficiaries receive. CMS supports provider payment reforms that would encourage quality and efficiency, and discourage increased complications and costs.

The President's Budget indicates support for linking quality to Medicare payment in a cost neutral manner. Given concerns about the overall financing of the Medicare program, providing additional aggregate funding to finance incentive payments is neither supportable nor necessary. On the other hand, savings obtained from reducing care that is unnecessary or otherwise inappropriate affords opportunities to fund incentive payments. Payment reforms should consider the possibilities for improving care coordination and using some of the savings generated in one payment system to fund incentives in another, as long as these reforms do not provide inappropriate incentives to stint on necessary care.

There appear to be two different administrative mechanisms to reward physicians who report information on quality measures. One approach would be a payment update differential, i.e., apply a higher update for a year to physicians who report quality measures for a prior period. This approach would apply the higher update to services furnished by physicians during a subsequent period. The alternative approach would be to make a lump sum payment adjustment after the end of a period based on reporting of measures during the period. We are examining the administrative issues involved with both approaches. We are also conducting a physician voluntary reporting program to allow physicians to report some existing quality measures and to allow us to test administrative mechanisms for reporting such measures. This program will provide valuable experience that will help us implement a mechanism that provides financial support to physicians who report measures.

8.
Question:
The President's budget includes a proposal to limit the rental period for oxygen equipment to 13 months. The Deficit Reduction Act (DRA) which passed the House on February 1st included a provision that transfers ownership of oxygen to the beneficiary after 36 months.

What would be the impact on the beneficiary if this proposal were enacted?

Based on purchase price information available on the internet – how do the payments made by the Medicare program compare? What are the components that make up the monthly payments for oxygen currently?

Is there a modality specific payment? If not – do you believe that suppliers will tend to supply the oxygen concentrator rather than spend more money to provide the higher technology oxygen equipment?

Answer:
The goal of the President's budget proposal is to make accurate Medicare payments in the program. Beneficiaries will save money with the President's budget proposal on oxygen equipment. Prior to the DRA, oxygen equipment was rented indefinitely and beneficiaries' coinsurance for the equipment vastly exceeded the cost of the equipment. On average, beneficiaries use oxygen and oxygen equipment for about 30 months. Oxygen concentrators, which account for over 90 percent of oxygen spending in 2004, are widely available for purchase at $1,000 or less. Thus, the total Medicare payment under current law for the average usage equals an average of six times the costs of the equipment. And the total beneficiary coinsurance would be greater than the cost of the equipment as well. This proposal would update Medicare payment to reflect current market prices.

The DRA provision caps the rental period at 36 months, after which time the beneficiary will own the equipment and neither Medicare nor the beneficiary will have to make any more monthly rental payments. Even with the rental cap at 36 months, beneficiaries will be paying about $440 over the cost of the equipment in coinsurance before owning it.

After the beneficiary owns the equipment, the DRA requires Medicare to pay for reasonable and necessary service and maintenance. The DRA also requires Medicare to continue to pay for gaseous and liquid oxygen contents for beneficiaries using stationary or portable oxygen tanks and cylinders after the beneficiary using that equipment owns it. Medicare will pay for reasonable and necessary service, maintenance, and repairs that are not covered under the supplier's or manufacturer's warranty after the beneficiary owns the equipment. The beneficiary would pay the 20 percent coinsurance for these costs.

Beneficiaries will continue to use their oxygen equipment as they did prior to the DRA. Medicare is changing the payment policy so that payment reflects accurate pricing for this equipment. The provision does not change the relationship between the beneficiary and the home oxygen supplier. After the beneficiary owns the equipment, he or she can still call the supplier when repairs, servicing and maintenance is needed just like before the DRA was passed. Medicare will pay for the costs of reasonable and necessary service and maintenance as Medicare does with other beneficiary owned equipment such as power wheelchairs. Medicare will also pay for replacement of supplies and accessories that are necessary to use the equipment, such as cannulas and tubing.

9.
Question:
The President's budget includes a proposal to reduce the ambulance fee schedule update by 0.4 percent from 2007 through 2009. The ambulance fee schedule started in 2004 and will be fully implemented in 2010. There have been several changes to the implementation of the national fee schedule – which has prolonged the effective date of final implementation.

Ambulance providers are still trying to work through the transition to a new fee schedule. An additional cut to the fee schedule could affect a number of rural providers that are struggling to maintain a profit margin.

It is my understanding that MedPAC has not recommended a reduction for ambulance providers. Do you believe that ambulance providers can withstand a reduction in their fee schedule for three years?

Answer:
We believe a small temporary reduction in ambulance updates can be absorbed by ambulance providers despite the transition to a national fee schedule. In fact, multiple supports were built into that transition to help cushion its effect, including extra payments for many rural providers, and a prolonged phase-in period still in effect in areas where providers would, on average, benefit from a longer transition.

10.
Question:
Each year hundreds of millions of dollars are lost to fraud, waste, and abuse of taxpayer funds in both the Medicare and Medicaid programs. Every dollar that Medicare and Medicaid lose to fraud or abuse represents one less dollar that can be spent on care for the most vulnerable populations of our society. Recognizing the dangers that these losses represent to the long term sustainability of both programs, Congress enacted the Health Insurance Portability and Accountability Act of 1996 which established the Health Care Fraud and Abuse Control account to combat fraud and abuse.

Contained in the FY 2007 budget is an overall increase in funding for fighting fraud and abuse in Medicare and Medicaid programs ($1.223 billion). While I am pleased that the administration continued to recognize the importance of sustained funding to root out fraud, waste, and abuse, I remain concerned about how these funds are allocated. More specifically:

What is the rationale for reducing the amount of funding to the Medicare Integrity Program from $832 million to $830 million?

a. Does HHS believe that this reduction will substantially reduce fraud and abuse control activities that were performed in FY 2006?

b. If yes, how does HHS plan to implement this reduction (i.e. which programs will face reductions)?

Please describe in detail what activities and projects are to be funded by the $273 million requested for "Other fraud and abuse control."

Answer:
Thank you for your interest in and support of our efforts to fight fraud and abuse in the Medicare and Medicaid programs. The year-to-year change in funding for the Medicare Integrity Program (MIP) reflects a number of factors, including the original MIP statute (the Health Insurance Portability and Accountability Act, or HIPAA), the amendments made to that statute by the Deficit Reduction Act of 2005 (DRA), and the President's fiscal year (FY) 2007 budget request for discretionary MIP funding. The following table displays the effect of those factors:

MIP FUNDING	MILLIONS OF DOLLARS		
	FY 2006	FY 2007	Difference
• Original statutory funding level	$720.0	$720.0	0
• DRA increase in general MIP funding	100.0	0.0	–100.0
• DRA increase in MIP funding, earmarked for Medicare-Medicaid data match	12.0	24.0	+12.0
• FY 2007 President's Budget request	N/A	85.6	+85.6
Total	$832.0	$829.6	–$2.4

If the President's request for discretionary MIP funds is enacted, CMS expects to maintain the level of effort in fraud and abuse activity in FY 2007. The $2.4 million decrease for the MIP activity will be more than offset by increases to the Department of Justice, the Department of Health and Human Services (HHS) Inspector General, and Medicaid program integrity. The following table shows our plan for using the funds in the President's budget to address fraud and abuse in the Medicare and Medicaid programs in FYs 2006 and 2007.

	(in millions of dollars)	
Funding Source	**FY 2006**	**FY 2007**
HCFAC: Medicare Integrity Program	$832	$830
HCFAC: Funding for FBI	114	114
HCFAC: HHS Inspector General, Department of Justice, and other	241	273
Medicaid Integrity Program	5	50
Total	$1,192	$1,267

As you can see, enacting the discretionary appropriation for this activity would provide total funding for the Health Care Fraud and Abuse Control (HCFAC) account in FY 2007, at $1.217 billion, a net increase of $75 million. Of that amount, $830 million is for the Medicare Integrity Program, as detailed in the first table. As set out in HIPAA, another $114 million is transferred directly to the Federal Bureau of Investigations for their work in health care fraud control. Again following the statute, at the beginning of the fiscal year, the Attorney General and the Secretary of HHS negotiate an agreement on the distribution of the remaining $273 million between the Department of Justice and the HHS Office of Inspector General, with a small amount reserved for projects in other HHS agencies. Specific projects and activities are selected during that negotiation process.

11.
Question:
What supports the QIOs as the most appropriate entities for assisting health IT in physician offices across the country?

Answer:
Quality Improvement Organizations (QIOs) are key resources to the Centers for Medicare & Medicaid Services (CMS), working to refine care delivery systems; investigate beneficiary complaints; safeguard the integrity of the Medicare Trust Funds; and build national partnerships with key provider organizations. QIOs also play an important role in developing quality measures that can be used to measure provider performance and spur quality improvement activities, and assist providers seeking to improve the quality of care delivered to Medicare beneficiaries. These efforts are essential to the Administration's goals to modernize and strengthen the Medicare program.

In his State of the Union address, the President stated that, "We will make use of electronic records and other health information technology to help control costs and reduce dangerous medical errors." To this end, I believe the QIOs play an important role in assisting with the adoption of health information technology (IT) in physicians' offices nationwide.

As part of their 8th Statement of Work (SOW) contract, which began on August 1, 2005, the QIOs are required to implement the Doctor's Office Quality-Information Technology (DOQ-IT) Project and are expected to recruit five percent of all primary care practice sites in each state. The goal of DOQ-IT is to improve the quality of care and safety for Medicare beneficiaries and all Americans by working directly with providers to increase awareness about the availability of high quality affordable health IT, and subsequently, providing assistance to physicians' offices in adopting and using such technology. As of January 31, 2006, recruitment has already reached two-thirds of the national goal of 3,900 participants. Based on these numbers, DOQ-IT is now the largest national program promoting the adoption of health IT by physicians.

Senator Baucus

1.
Question:
Health Information Technology: To get to a national health information network – with its resulting benefits in safety, health outcomes and cost savings – we need to see more widespread use of electronic

medical records and other health IT tools. That way, as the network forms, there will be more connection points. Some large hospitals and academic medical centers have capital resources to invest in electronic medical record systems. But many others – especially small, rural, charity or otherwise under-capitalized providers – do not. What are the financial incentives that the Administration proposes to facilitate hospital and physician investment in health IT?

Answer:
The Administration will focus on available incentives to facilitate hospital and physician investment in health IT that can mitigate the gap in adoption of health IT by clinicians and providers based on size and resources. This includes looking at the exception to the Physician Self-Referral Law as well as the related safe harbors for the Anti-Kickback Statute. Policies such as this will focus on certified health IT.

In addition to policies which the Administration can tie to certification of health IT, certification by itself has the potential to facilitate hospital and physician investment. Certification will allow buyers of health IT to have greater price-transparency. If two systems are certified as meeting minimum set of requirements for features, functions, interoperability, and privacy/security, then a hospital or physician can ask why one EHR costs more or less than another EHR. This will create more certainty among buyers and will have the added benefit of more competitive pricing. Further, certified EHRs will require less integration work, and will be plug-and-play for clinicians and hospitals. This reduces the risk of implementation failure and also drives down the costs of implementation.

2.
Question:
Health Information Technology: I was pleased to see the Administration publish proposed rules to reduce legal barriers to health IT adoption by creating exemptions and safe harbors within Stark and anti-kickback Laws. But I am concerned that the vagueness of the proposed rules may mean that few providers will take advantage of the exemptions until they have been tested in court. When does the Administration plan to publish the final rules? How does the Administration plan to educate providers to make the legal bounds of the rule explicit?

Answer:
We expect to publish final rules this year establishing Stark exceptions and anti-kickback safe harbors for health IT. We received a large number of comments on the proposed regulations from provider organization and health IT industry representatives, many of whom expressed a preference for clear cut rules. We are taking those and other comments under considerationin developing the final rules.

3.
Question:
Pay-for-performance: The President's budget discusses payment incentives to encourage the delivery of quality health care, echoing the model in S. 1356, the Medicare Value Based Purchasing Act of 2005, which Senator Grassley and I introduced and which passed the Senate late last year as part of budget reconciliation legislation. Please explain in more detail how the Administration proposes to implement their pay-for-performance goals. Will the Administration support the Grassley-Baucus bill?

Answer:
The Administration is committed to developing reporting and payment systems that enable us to support and reward quality and improve care, without increasing overall Medicare costs. When clear, valid and widely accepted quality measures are in place, pay-for-performance is a tool that will enable Medicare reimbursement systems to better support efforts to improve quality and avoid unnecessary costs.

Congress has recognized the benefits of moving to a payment system that rewards high quality care by putting in place the building blocks that will provide a sound foundation for a future pay-for-performance system. To promote the development of quality measures and the reporting of such measures, the Deficit Reduction Act contains two provisions related to quality reporting for hospitals and home health agencies.

Building off the structure for hospital quality reporting included in Section 501(b) of the Medicare Modernization Act of 2003 (MMA), the Hospital Quality Improvement provision included in the DRA

requires CMS to expand the set of hospital quality measures that hospitals report beginning in FY 2007, while increasing the financial incentive for hospitals to report such measures. This provision also is forward-thinking, requiring the Secretary to develop a plan to implement a value based purchasing program for hospitals beginning in FY 2009. The plan must include consideration of such issues as the development, selection and modification of measures; the reporting, collection and validation of quality data; the structure of value based payment adjustments; and the disclosure of performance information.

The Home Health Payment provision included in the DRA expands pay-for-reporting to another set of health care providers, adjusting the annual payment update for home health agencies for 2007 and subsequent years. The provision also recognizes the need for additional research and careful analysis, directing the Medicare Payment Advisory Commission to submit a report with recommendations on a detailed structure of value based payment adjustments for home health services by June 1, 2007.

With regard to physicians, the Centers for Medicare & Medicaid Services (CMS) launched the Physician Voluntary Reporting Program (PVRP) on January 1, 2006. In the first phase of the PVRP, CMS will ask physicians to voluntarily report information about the quality of care they provide to Medicare beneficiaries. Physicians who choose to participate in the PVRP will help capture data about the quality of care provided to Medicare beneficiaries in order to identify the most effective ways to use the quality measures in routine practice to improve the quality of care. The PVRP was designed to provide evidence that quality measures are sensible, practical, and provide the mechanism to recognize better care in actual practice. In the future, reporting could be implemented in conjunction with larger physician payment updates, taking us that much closer to a feasible and sustainable approach to move away from the Sustainable Growth Rate.

In addition to these efforts, CMS is implementing a number of demonstration projects aimed at encouraging quality care and designed to lay the groundwork for pay-for-performance systems in the future. These include the Physician Group Practice Demonstration, the Premier Hospital Quality Incentive Demonstration, the Health Care Quality Demonstration, and the Care Management Performance Demonstration. These projects are helping us to examine our current systems to better anticipate patient needs, especially for those with chronic diseases, and explore how incentives can be better aligned with the kind of care we want.

There is more evidence than ever before that these approaches can work, from the private sector and now in Medicare. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers, while also promoting the highest quality of care without increasing overall Medicare costs.

4.
Question:
Pay-for-performance: I believe that we need to encourage not only providers who already provide the highest quality, but also those who are improving year-by-year. Otherwise, we will end up with a further fragmented health care system. Do you agree that we need an approach that will "lift all boats" by increasing quality throughout the health care system? How does the Administration propose implementing pay-for-performance to "lift all boats," encouraging more providers to provide better quality care?

Answer:
The current Medicare payment systems do not provide incentives for providers to take into account all of the services furnished to beneficiaries during an episode of care, or furnished during a period of time to treat chronic disease. This often has the effect of directing more resources to delivering care that is not of the highest quality (for example, duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications). Conversely, providers who have good ideas and want to take action to improve quality of care find that Medicare's payment systems do not provide them with the resources or the flexibility needed to do so. As a result, providers are unable to invest in activities that, properly implemented, have the potential to improve quality and avoid unnecessary medical costs.

Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that result in improvements in the value of care that our beneficiaries receive. The Administration supports provider payment reforms that would encourage quality and efficiency, and discourage increased complications and costs.

The President's Budget indicates support for linking quality to Medicare payment in a cost neutral manner. We believe that savings from reducing care that is unnecessary or otherwise inappropriate affords opportunities to fund incentive payments. We believe we should examine possibilities of improving care coordination and using some of the savings generated in one payment system to fund incentives in another, as long as these reforms do not provide inappropriate incentives to deny necessary care.

5.
Question:
Urban Indian Health: The President's 2007 Budget proposes eliminating the Urban Indian Health Program, citing this as one of several programs cut because they were "duplicative, inefficient, or not producing results." Did the Administration consult with the Tribes before proposing this cut? Please explain in detail how the Urban Indian Health program was evaluated, and provide a thorough rationale for the proposed cut.

Answer:
The Department of Health and Human Services consults annually with Tribes in the development of its budget requests. During consultation on the FY 2007 budget, many Tribal representatives stressed the difficulty of providing health care to a growing population as the cost of providing this health care increases. The Administration's FY 2007 budget request for the Indian Health Service includes an increase of $134 million for increased pay costs of Federal and Tribal staff, population growth, and other increases in the cost of providing health care.

The Urban Program was proposed for elimination because, unlike Indian people living in isolated rural areas, urban Indians have access to other health facilities funded by Medicaid, and other Federal, State and local health programs, on the same basis as all Americans. Most urban Indian clinics already receive funding from some or all of these sources. If fact, these other sources make up nearly 2/3rd of total Urban clinic revenue.

The budget also includes increases in other areas that expand services to Indian people who do not live on or near reservations. A +$181 million increase is proposed for one such program, HRSA Health Centers. Recent funding increases will allow Health Centers to serve 8.8 million low-income urban Americans in FY 2007,1.5 million more urban Americans than were served in FY 2004. Health Centers operate in all 34 of the cities served by the Urban Program and in hundreds of other cities where Indian people live.

6.
Question:
Urban Indian Health: Providing health care to Native Americans is a treaty obligation of the United States. Today, nearly 60% of Native Americans live in cities, making urban Indian health centers critical to fulfilling that obligation. In light of the proposed elimination of this program, the Administration suggests that community health centers can fill the gap. But community health centers currently have long waiting times and are often unable to meet existing demands for care. They also require payment on a sliding scale from those able to pay, while the IHS and urban Indian clinics provide free care to Indian Country. Finally, community health centers provide only outpatient services. Given these facts, what additional assistance does the Administration propose to ensure that community health centers can handle additional patients without charging coinsurance, and to fulfill emergency and inpatient health care needs in Indian Country?

Answer:
IHS and HRSA staff are meeting to discuss how urban clinic patients will receive care in the future. Options include assisting urban clinics in applying for Health Center funding (4 urban clinics receive this funding already) and serving additional urban Indians in Health Centers, through IHS, and with other State

and local resources. As mentioned above, increased Health Center funding will allow this program to serve 1.5 million more urban patients than it served in 2004.

7.
Question:
Medicare Sequestration: The budget proposes giving the Administration authority to cut Medicare provider payments by four-tenths of a percent if the program's financing from general revenues reaches 45 percent of Medicare spending in a given year. If general revenues for Medicare are expected to exceed the 45 percent target, the budget proposes sequestration that appears to apply to all provider payments equally, even though some providers may have much higher Medicare margins than others. For example, if the target were reached in a year in which physician payment was scheduled to be cut (as has been the case for the last several years), it appears that physician payment would undergo an additional 0.4 percent cut under the President's proposal. Is that the case? If Medicare payroll tax revenues dropped significantly during a recession, would the Administration's proposal still force automatic across-the-board cuts in Medicare provider payments? Since cutting spending during a recession is generally considered unwise, isn't this a serious flaw with the proposal?

Answer:
The MMA establishes a Medicare Funding Warning system. The provision requires that the Medicare Trustees' Report include a comprehensive fiscal analysis of the program's financing and a determination as to whether general revenues are projected to exceed 45 percent of total Medicare financing. If the 45 percent threshold is exceeded for two years during a seven-year projection period, then a Medicare Funding Warning occurs.

Current law requires that, if a "Medicare funding warning" occurs, the President must submit to Congress, within 15 days after the date of the next budget, proposed legislation to bring general revenue spending below 45 percent of total outlays. The House and Senate are each required to consider this legislation on an expedited basis. The President's FY 2007 Budget proposes to put into place a fallback policy for automatic action if the legislative process does not result in action to rectify the deficit.

The President's Budget builds on the existing Medicare Funding Warning law to support continuing efforts to enhance Medicare's long-term sustainability. Specifically, if the 45 percent threshold were met and Congress failed to act on recommendations to sustain Medicare's financing, then a four-tenths of one percent reduction to all Medicare payments would be implemented to decrease excess general revenue Medicare funding. The reduction would grow by four-tenths of one percent every year that the 45 percent threshold is exceeded.

The general revenue Medicare funding ratio is currently fairly close to 45 percent and is expected to increase gradually. Once triggered, the reductions in payment amounts under the President's Budget proposal would likely remain in effect for many years. Whether general revenues exceed 45 percent of total Medicare financing during a recession or an expansion, the amount of the excess funding still needs to be addressed. Deferral of a sequestration only to periods of expansion would require a larger sequestration during such periods. The proposal applies to all providers of services and suppliers (as such terms are defined for purposes of Title XVIII) as well as to entities offering plans under Part C or Part D

8.
Question:
Medicaid Rebate: The President's budget includes a proposal to eliminate the current Medicaid rebate and replace it with a "budget neutral flat rebate." The budget asserts that best price prevents manufacturers from negotiating better discounts with large purchasers because they are reluctant to offer deep discounts because it will increase the rebate they owe to Medicaid. Please describe this proposal in more detail. What would the flat rebate be? Would it remain a percentage of AMP? If so, what percent? Moreover, the Administration claims this proposal will be budget neutral. How is this so? Does that apply to both federal and state budgets?

Answer:
Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. Approximately 550 pharmaceutical companies currently participate in this program. Forty nine states (Arizona is excluded), and the District of Columbia cover drugs under the Medicaid Drug Rebate Program.

As of January 1, 1996, the basic rebate for innovator drugs is the larger of 15.1 % of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the best price per unit. The rebate for non-innovator Drugs is 11 % of the AMP per unit.

Best price represents the lowest price available for the drug with certain statutory exceptions. This figure functions as a price floor, which prohibits manufacturers from negotiating deeper discounts with large non-Medicaid purchasers such as hospitals and HMOs. The 2007 President's Budget proposal would help to administratively simplify drug rebate calculations and allow private purchasers to negotiate lower drug prices. Because this proposal is budget neutral, the States will not be disadvantaged by lower prices, which large volume, private purchasers may get.

9.
Question:
Average Manufacturer Price: The President's Budget includes a proposal to reduce the generic drug payment to average manufacturer price (AMP) plus 150%, further reducing such payments beyond the decreases imposed by the Deficit Reduction Act (DRA), which the President just signed. Please describe this proposal in more detail. How can you be sure that the payment formula contained in the DRA, which is based on average manufacturer price, will result in overpayments, especially when AMP is an unproven payment metric for generic drugs in the Medicaid program? Isn't it premature to change the formula before the Inspector General reports on AMP, as required by the DRA?

Answer:
The Centers for Medicare & Medicaid Services is committed to helping states reduce Medicaid drug costs. As part of a commitment to reduce drug costs, CMS actively encourages the use of generic alternatives in place of brand name products. This is partly achieved through the use of the Federal Upper Limit (FUL), a program that sets limits on what State Medicaid program can pay for brand name drugs that have a therapeutically equivalent generic medication. The FUL program is intended to assure that the Medicaid program acts as a prudent buyer of drugs. The concept of the upper limits program is to achieve savings by taking advantage of the current market prices.

Under prior law, the FUL was set at 150% of the price of the lowest cost drug in the category as reported in published drug pricing compendia. Over time, the FUL was increasingly less effective in assuring that the Medicaid program paid appropriately for multiple source drugs. This has been documented in studies by the Inspector General for the Department of Health and Human Services, in a report by the bipartisan Medicaid Commission, and in testimony before House Energy and Commerce Committee by Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare & Medicaid Services (CMS). Over time, these reported prices have become less reliable as estimates of the true acquisition cost of drugs.

The DRA revised the way in which the FUL is calculated by changing the reference point for the FUL calculation from prices published in pricing compendia to the Average Manufacturer Price (AMP) and set the FUL for multiple source drugs was 250% of the lowest cost product among the therapeutically equivalent products. AMP is the only proven payment metric for drug pricing as it is the only measure based on the actual cost of the sale of drugs in the marketplace.

The Budget proposal builds on DRA changes to the Federal upper limit for multiple source drugs by limiting reimbursement for multiple source drugs to 150 percent of the AMP. This will continue efforts to further reduce Medicaid overpayments for prescription drugs. States would have the flexibility to support

innovative approaches to lower drug costs, such as paying pharmacists more when they help patients use less expensive generic drugs.

The FUL, which set for each drug, may be exceeded by States for selected drugs if the State offsets this added cost by reducing payments for other FUL drugs. Because the limit is applied in the aggregate, States have flexibility to raise the prices paid for certain drugs to address supply issues in the State or pay more to categories of pharmacies (eg., small independents that may be required to pay higher wholesale prices).

We believe that flexibility is essential to ensure that the States have adequate tools to set appropriate payment rates and worked hard to ensure that this feature was retained in the new law.

It is also important to note that States may pay pharmacies higher prices for brand name drugs subject to the FUL if a physician attests that the brand drug is medically necessary for the patient.

10.
Question:
HCFAC: The President's Budget includes an increase in funds devoted to fighting fraud, waste and abuse in the Medicare and Medicaid programs. Please describe in detail how the additional funds will be used to fight fraud, waste and abuse in these two programs. Please also explain why the budget proposes a slight reduction in the funding for the Medicare Integrity Program, especially given that the new Medicare drug benefit has just gotten underway.

Answer:
Thank you for your interest in the Department's efforts to fight fraud and abuse. To be most responsive, I am going to address your second question first. The year-to-year change in funding for the Medicare Integrity Program (MIP) reflects a number of factors, including the following:

- the $720 million in funding authorized under the original MIP statute (the Health Insurance Portability and Accountability Act, or HIPAA);
- the one-time $100 million increase in funding in FY 2006 provided by the Deficit Reduction Act of 2005 (DRA) for general MIP activities;
- the $12 million increase in funding in FY 2006 earmarked for the Medicare-Medicaid data match (increasing over a 5-year period until it reaches an annual maximum of $60 million); and
- the President's FY 2007 budget request for $85.6 million in discretionary MIP funding.

The slight decrease in funding in FY 2007 from FY 2006 funding levels is deceptive in that FY 2006 funding reflects a substantial increase over FY2005 due to the one-time $100 million increase in funding provided by the DRA. If the discretionary appropriation requested by the President is enacted, funding over the two-year period will remain roughly level, at a significantly higher amount than the $720 million that was available for MIP over the last several years.

	(in millions of dollars)			
Funding Source	**FY 2006**		**FY 2007**	
HCFAC: Medicare Integrity Program				
• Original statutory funding level	$720		$720	
• DRA one-time increase	$100		$0	
• DRA increase for data match program	$12		$24	
• President FY 2007 Budget Request	N/A		$85.6	
HCFAC: Medicare Integrity Program		$832		$830
HCFAC: Funding for FBI		$114		$114
HCFAC: HHS OIG, DOJ, and other		$241		$273
Medicaid Integrity Program		$5		$50
TOTAL— Medicare and Medicaid Fraud and Abuse Funding		$1,192		$1,267

As you can see in the table above, enacting the discretionary appropriation for fighting fraud and abuse in the Medicare and Medicaid programs would provide a net increase of $75 million in FY 2007.

In addition to the ongoing program integrity work in the traditional Medicare program, the resources for the Medicare Integrity Program will be used for such activities as audits of Part D prescription drug plans; expansion of data matching activities to include Part D; and contracts for data analysis to discover fraud or abuse, investigate potentially fraudulent activities and fraud complaints, and develop cases for referral to enforcement agencies. Prior to the DRA, work in the Medicaid area, funded under the Medicare Integrity Program, included investigative and enforcement work by the Department of Justice and the Department of Health and Human Services Office of Inspector General; measuring and improving accuracy in the State-run Medicaid programs; review of State Medicaid financial management activities; and a data match between the Medicare and Medicaid (Medi-Medi) programs, which helps uncover patterns of questionable practices in both programs.

In terms of fighting fraud, waste, and abuse specifically in the Medicaid program, the DRA adds to our previous efforts, creating a new program, with new staffing and new funding to establish a Medicaid Integrity Program. The statute mandates CMS to enter into contracts with eligible entities to perform certain very specific anti-fraud activities.

These activities include:

1) Reviewing actions of providers;
2) Auditing provider claims;
3) Identifying overpayments; and,
4) Educating providers.

The statute requires CMS to establish a detailed 5-year plan, in consultation with many stakeholders, beginning with FY 2006, for combating fraud, waste and abuse in the Medicaid program. The statute also increases CMS staffing by 100 FTEs, whose duties consist solely of protecting the integrity of the Medicaid program. The legislation also provides funding, starting with $5 million in FY 2006, $50 million for each of FYs 2007 and 2008, and $75 million for FY 2009 and each fiscal year thereafter. This funding is "new money" and not part of HCFAC. Finally, another provision of the DRA (Section 6031) provides an incentive for states to enact their own State False Claims Acts. For these states, the state share will increase by 10% for any amounts recovered under these state laws.

CMS is working to implement these provisions of the DRA in as timely a fashion as possible.

11.
Question:
Medicare Bad Debt: As you know, the Deficit Reduction Act (DRA) reduced Medicare bad debt payments to skilled nursing facilities to 70%, down from 100%. Bad debts for those dually eligible for Medicare and Medicaid beneficiaries will continue to be paid at 100%. The president's FY 2007 budget proposes a significant extension of this policy, down to zero percent, applying to all Medicare providers who currently receive bad debt payments. Is it your contention that providers should suffer financially without recourse to Medicare if the beneficiary fails to pay for services provided? Please provide details of this proposed policy change.

Answer:
Thank you for your interest and concern regarding the Medicare bad debt program and fair reimbursement for Medicare providers. As the stewards of the Medicare Trust Funds, it is important that we encourage providers to be proactive in pursuing the bad debts owed to them. We believe that a reduction in bad debt reimbursement will create greater incentives for providers to recoup their debts, leading to greater program efficiency and strengthening the long-term financial security of the Medicare program.

Currently, Medicare is the only payor that reimburses bad debt for services paid on a reasonable cost basis or under a prospective payment system. The provision in the President's budget will put Medicare in line with commercial payors and practices.

We do not believe that this provision will cause providers to suffer financially because bad debt is only a small fraction of Medicare revenues for providers. For example, the reduction in Medicare bad debt payments accounts for less than 1.0 percent of revenues for hospitals, only 0.5 percent of Medicare revenues for skilled nursing facilities, and 0.1 percent for dialysis facilities. This is a very small portion of each provider's Medicare revenues, but added together it is a measurable amount of Medicare program dollars.

12.
Question:
SHIP Enrollment Targets: I understand that some State Health Insurance Assistance Programs (SHIP) grants included enrollment targets and incentives that conditioned receipt of funding on the SHIPs' proof of enrollment of a target number of beneficiaries, or paid out a set amount per beneficiary. This type of grant appears to violate the mandate that SHIPs provide neutral beneficiary advice and advocate for the interests of the beneficiary, not any particular prescription drug plan, or Medicare itself. Please answer the following questions about SHIP grants:

a. How many contracts awarded by, or in cooperation with, CMS and/or AoA include similar provisions that condition funds in whole or in part on attainment of an enrollment target? How does this compare with the total number of contracts awarded by, or in cooperation with, CMS and/or AoA? How much funding is at stake?

b. Are these contracts consistent with SHIPs' mandate to provide neutral advice to beneficiaries about a voluntary prescription drug benefit?

Answer:
CMS does not have contracts with SHIPs, nor has it set enrollment targets for SHIPs. The SHIP grant application outlines CMS' expectations of SHIPs specifically to provide objective and impartial enrollment assistance to as many beneficiaries as possible. Separate and apart from SHIP grants, CMS and AoA have an intra-agency agreement through which nine national organizations and more than a hundred community-level organizations are sub-contracted by n4a to provide enrollment assistance to vulnerable beneficiaries. To ensure that the contracts were focused on enrollment assistance, enrollment targets were originally included in all contracts. The contracts were later modified to include only tracking and reporting of activities without any condition on attainment of enrollment targets. Subcontractors are required to follow the same guidelines for objective and impartial enrollment assistance that CMS provides to SHIPs. There are no other CMS beneficiary outreach contracts, intra-agency agreements or grants that involve targets at this time.

13.
Question:
Medicare Health Savings Accounts: Please provide further detail on your proposal to extend Health Savings Accounts to Medicare. How many Medicare beneficiaries do you expect to participate in such a program?

Answer:
Health Savings Accounts (HSAs) are tax-favored accounts which were created in the MMA for the non-Medicare population. HSAs are used in conjunction with a High Deductible Health Plan (HDHP) to pay for current and future medical expenses, however, Medicare beneficiaries are required to stop contributing to their HSAs as of the month they become entitled to Medicare.

Current law does allow for the establishment of Medicare Medical Savings Accounts (MSAs) and, in fact, we are taking steps to further facilitate the development of MSA products for Medicare beneficiaries. In the future, we fully expect that Medicare MSA coverage will become a part of Medicare and that they will

give beneficiaries the choice of continuing with the type of coverage to which they are accustomed. It is too early to project actual enrollment numbers for Medicare MSAs at this stage of the development process, however, based on the growing popularity of this coverage model outside of Medicare, it is fair to expect a robust enrollment in such products.

14.
Question:
Clinical Labs Competitive Bidding: The President's budget proposes extending competitive bidding to laboratory services. As you know, the MMA required HHS to conduct a demonstration program for competitive bidding of laboratory tests. An initial report to Congress was required of the Secretary no later than December 31, 2005, with progress and final reports as the Secretary determines appropriate. Two phases are anticipated for the demo contract: the first lasting 18 months, with a potential phase II lasting up to 42 additional months. Since the specifications for the clinical laboratories demo are still being developed, why is the Administration proposing to move ahead with a national competitive bidding program for these services in advance of the demo? Furthermore, the President's Proposed 2007 Budget assumes savings for this program of roughly $1.43 billion over four years. Without input from the competitive bidding demonstration project, how does the Administration arrive at these savings assumptions?

Answer:
Like durable medical equipment (for which nationwide competitive acquisition was required by the MMA), clinical laboratories provide discrete services pursuant to a physician's order. Such services involve routine steps and procedures for which costs may be readily calculated. Thus, we believe these services are ripe for competitive acquisition, which can be expected, by its design, to yield significant program savings.

This approach is consistent with the President's goal of increasing market-based competition and efficiency in Medicare. While information derived from a demonstration could be useful, we believe it is both possible and preferable to move more expeditiously toward this goal.

15.
Question:
Medicare Provider Payments: The president's budget proposes reductions of 0.4% in Medicare payments for both ambulance and hospice providers in each of 2007, 2008 and 2009. Please provide background on the analysis HHS used to arrive at these proposals. Also, noting your reference to the Medicare Payment Advisory Commission recommendations as the basis for your 2007 proposals on home health, skilled nursing and hospital payment, please provide your rationale for reducing these providers' payments in 2008 and 2009. Finally, given that apparently relied on MedPAC for at least some of your fee-for-service proposals, what is your rationale for ignoring MedPAC's recommendations on Medicare Advantage?

Answer:
In order to ensure the strength and long-term sustainability of the Medicare program, it is important to regularly consider the need for payment updates as well as other payment policy changes. In keeping with the proposals for home health, skilled nursing facilities, and hospital payments, as you note, the President's Budget also includes proposals to reduce the amount of the annual payment updates to ambulance and hospice providers for years 2007-2009. This across the board approach for all providers builds on long-term Administration priorities for the Medicare program, such as improving quality and preventing medical errors, encouraging efficient and appropriate payment for services, fostering competition, and promoting beneficiary involvement in healthcare decisions.

With regard to home health services, research has shown that beneficiaries continue to have access to such services, with the number of beneficiaries using home health services increasing over time. For example, Medicare Payment Advisory Commission (MedPAC) data show the number of home health users increased from 2.6 million in 2003 to 2.8 million in 2004. Similarly, the number of home health agencies (HHAs) continues to grow and profit margins remain high. In 2004, profit margins for HHAs reached 16.0 percent. The projected margin for 2006 is 14.7 percent. The combination of increased utilization of home health services, increased numbers of HHAs, and significant margins prompted MedPAC to recommend

eliminating the payment update for these services in 2007. In accordance with this conclusion, the President's Budget proposes such a policy for 2007, and suggests reduced payment updates in 2008 and 2009 to encourage efficient and appropriate payment for home health services into the future.

Research has also shown that beneficiaries continue to have access to skilled nursing facility (SNF) services, as current trends indicate a stable supply of SNFs for 2005 and an increase in the volume of SNF services. The March 2006 MedPAC report includes a recommendation to eliminate the payment update for SNF services for fiscal year (FY) 2007, given that aggregate Medicare margins for freestanding SNFs are projected to reach 9.4 percent in FY 2006. A similar forecast is seen for the years ahead and serves as the basis for the Administration's proposal to reduce payment updates for FYs 2008 and 2009.

Similarly, MedPAC's analysis of hospital payment adequacy indicates that there has been no significant change in hospitals' capacity to provide services to Medicare beneficiaries. Both inpatient and outpatient volume has increased, and spending on hospital construction has been growing. Although MedPAC reports that Medicare margins are decreasing, this can be attributed to unusually rapid cost growth due to unusual cost pressures, the lack of financial pressure to constrain costs, and the fact that hospitals with consistently high costs may not be efficient or competitive in their own markets. Consistent with MedPAC's recommendation and to ensure that Medicare payments reflect the costs of efficient providers, the Administration proposes to provide hospitals with a market basket update that encourages efficiency and productivity.

With respect to Medicare Advantage (MA) capitation rates, the methodology in law requires CMS to update the rates each year using either national Medicare rates of growth or, for some counties and in some years, county-level fee-for-service Medicare rates of growth. Reductions in payments for the services described in your question are reflected in reductions in Medicare growth rates, which directly affect the MA capitation rates. Thus, the Medicare law is already structured so that MA rates are affected by reductions in fee-for-service Medicare spending.

We are aware that MedPAC recommends changes that would significantly reduce MA funding for some areas, including many rural areas. The new regional PPO option, intended to bring more MA options to rural areas and provide more PPO options in urban areas, became effective in 2006. About ¾ of states now have statewide regional PPO options. As you know, for several years before the Medicare Modernization Act of 2003 was enacted, the MA program, and most importantly many beneficiaries enrolled in MA plans, struggled because of the effects of Medicare payment updates that did not keep up with plans' cost increases. We believe implementation of these recommendations could lead to a new period of destabilization and disruption for beneficiaries enrolled in MA plans or, at a minimum, higher costs and benefit reductions for enrollees.

16.
Question:
Medicare Physician Payments: As you know, as a result of the Sustainable Growth Rate (SGR) formula, the Medicare physician fee schedule is set to be reduced by over four percent in 2007. Last year, over 90 senators urged the Administration to remove Part B drug expenditures from the SGR. Doing so would improve Medicare physician updates, allow Congress to concentrate on a long-term solution to the problem, and reduce physicians' uncertainty regarding Medicare physician payment. What does the Administration propose to alleviate the problem of a physician payment cut in 2007?

Answer:
The Deficit Reduction Act (DRA) of 2005 eliminated the negative physician update that would otherwise have taken place for 2006. In 2006, the physician community is developing quality measures that would cover a broad group of physician specialties and a wide range of clinical areas for physicians to begin reporting in 2007. We are working closely with the physician community to develop these evidence-based quality measures. During 2006, we are conducting a physician voluntary reporting program to allow physicians to report some existing quality measures and to allow us to test administrative mechanisms for reporting such measures. We are also examining the administrative issues that would be involved with alternative mechanisms to reward physicians who report information on quality measures. As the year

transpires, we will assess progress in the development of performance measures for physicians, as well as mechanisms for the reporting of measures in 2007. This will provide physicians with the opportunity to report measures first, leading to payment for reporting and performance on such measures in the future. We would be happy to work with you and your colleagues on the physician update issue for 2007 and future years.

17.
Question:
TANF: The recently-passed budget reconciliation bill requires HHS to promulgate new TANF regulations by June 30, 2006. How does HHS intend to establish a TANF regulatory process that includes meaningful input from states and other TANF stakeholders?

Answer:
We intend to issue an interim final rule, which addresses the specific TANF provisions of the Deficit Reduction Act of 2005 within the expedited timeframe established by Congress. Once this rule is published, interested parties will have 60 days from publication to submit written comments to us on the regulatory provisions. We will carefully evaluate these comments to determine whether any changes in the regulatory provisions are necessary.

18.
Question:
Marriage and Fatherhood Promotion: Given that the president's FY 2007 budget proposes specific funds for marriage and fatherhood promotion, does HHS intend to continue using funds from other programs (such as child support) for marriage and fatherhood promotion? What are HHS' plans to distribute marriage promotion and fatherhood initiative funds in an open competitive process? Finally, how does HHS plan to evaluate the effectiveness of these programs?

Answer:
Although the Deficit Reduction Act (DRA) of 2005 provides new funding for activities within the TANF program to support healthy marriage, ACF will continue to support healthy marriage and responsible fatherhood activities within other programs as well, when such activities can further the missions of those programs. Examples include child support, child welfare programs, and refugee programs.

Grants to support the activities authorized in the DRA for healthy marriage and responsible fatherhood will be awarded through an open competitive process. We will follow the usual processes for discretionary grant programs throughout government. An announcement of the availability of funds with instructions for making applications will be made available to the public through grants.gov. Applications will be reviewed and assigned a score by a panel of independent peer reviewers using the evaluation criteria included in the published announcement. Panel reviewers will be screened for conflicts of interest and given thorough training before reviewing grants.

HHS will continue to invest in and support research and evaluation in order to learn what works best with regard to healthy marriage and responsible fatherhood services. We are funding two separate major evaluations that will use a rigorous evaluation design, involving the random assignment of couples to program and control groups, in order to assess whether marriage education programs for low-income unmarried parents and married couples who volunteer to participate are effective or not. These evaluations will include numerous programs around the country and they will track couples/families in both the program and control groups and measure outcomes for couples and children over several years. We are also funding a major evaluation of community healthy marriage programs that involve multiple sectors within communities including governmental, non-profit and faith-based organizations in activities in support of healthy marriage.

19.
Question:
Medicaid: The Deficit Reduction Act of 2005 gave states substantial new flexibility regarding Medicaid cost-sharing and benefits and gave CMS new authority to initiate a 10 state Medicaid demonstration

program. Yet your budget states that you will be implementing a new waiver initiative that allows states to go beyond the authority in the new law. Could you tell us more about this initiative and why you think it is appropriate to go beyond the bounds of what Congress has just enacted? How would the new waiver initiative differ from the one recently enacted? To the extent that it would follow the model established in the Florida waiver, what protections would exist to ensure that Medicaid beneficiaries have guaranteed access to medically necessary services even after they have exhausted their annual allotment? What due process provisions would apply to ensure that private plan decisions regarding medical necessity would be appealable to a state agency, as they are under current Constitutional precedent?

Answer:
The purpose of our waiver proposal is to expand health insurance coverage. While the Deficit Reduction Act of 2005 (DRA) provided a new option to expand coverage for children with disabilities as well as a demonstration to assist those in institutions transition to community-based care, it did not create new opportunities for states to address the issue of the uninsured.

Building on the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative and approaches adopted by innovative states such as Florida and Arkansas, the Administration will develop a new waiver initiative that emphasizes market-driven approaches to health care. In conjunction with the Deficit Reduction Act of 2005 (DRA), this approach allows states to emphasize expanding needed coverage to uninsured individuals and to promote greater continuity of coverage. This new model will stress consumer-driven approaches to health care with access to affordable coverage while giving states more tools to offer better health coverage to some current beneficiaries, as well as to individuals who are currently uninsured. By broadening choices and encouraging competition in the private market, Medicaid can continue to modernize through state-level reforms. The result will be more seamless access to coverage for low-income families and children in Medicaid, as well as to other uninsured persons with limited incomes.

While further details of the new Federal waiver initiative are being developed, this new model for demonstration initiatives will build upon past CMS and state successes with initiatives that include public-private partnerships, consumer and market-driven health care, tax credits, high-risk pools and premium assistance. HIFA demonstrations, which began in the fall of 2001, have allowed states to provide health care to more beneficiaries with the same amount of funding by changing delivery systems, redirecting current health care dollars to provide expanded coverage, and working with employers to ensure that employer-sponsored insurance (ESI) options remain available, and are in fact expanded. As of November 2005, over 800,000 individuals are eligible to receive health insurance coverage through HIFA demonstrations. The Administration hopes to increase this number by providing even more options to states for demonstrations to offer better health coverage to current beneficiaries as well as to expand coverage to the uninsured.

CMS will be making sure it gives states the options and tools they need to stay on the forefront of twenty-first century innovations in health care delivery and financing. Even since the recent implementation of the HIFA demonstrations, there have been additional innovations in the health care market through increased consumer information and decision-making, emphasis on personal responsibility and health care efficacy, and chronic care management coupled with technology. These developments allow new options that can benefit Medicaid and SCHIP enrollees. Consumer-driven options, along with other integrated market driven efforts, create opportunities for states to leverage this new flexibility to realign and reorganize their resources and funding streams to promote private market health coverage solutions through public/private partnerships and other approaches. Specific strategies could include ESI subsides in lieu of enrollment in Medicaid/SCHIP, Health Savings Account (HSA) and other incentive-based program features, Deficit Reduction Act (DRA) benefit flexibility, tax credits, transformation of categorical eligibility to income-based, and the collective power of coalescing divergent funding to encompass a greater share of low income working individuals and families.

20.
Question:
Medicaid: Most of the changes your budget proposes to make in Medicaid by either legislative changes or changes in regulation would save money for the federal government but not for states. For example several changes you propose would reduce federal funds that go towards the cost of state administration of the

Medicaid program. Isn't it likely that states will have to reduce coverage or provider payments to deal with the loss of these federal funds?

Answer:
As a former Governor I believe it is far more likely that the states will find sufficient resources to appropriately manage the largest single source of federal funds a state receives.

21.
Question:
Medicaid: The budget proposes making further changes to the targeted case management services now covered under Medicaid, beyond those just enacted in the Deficit Reduction Act of 2005. Given that many of the services states provide to at-risk populations under the TCM benefit have an administrative component, how would CMS define which services should be billed as administrative services only?

Answer:
Case management services may be reimbursed under the Medicaid program either as a medical assistance service or as an administrative activity. Where the case management activity is reimbursed as a medical assistance service, it is reimbursed as the state's medical assistance percentage. Currently 39 states have a Federal medical assistance percentage (FMAP) over 50%. Where it is reimbursed as an administrative activity, it is generally reimbursed at a 50% administrative match rate. However, where the activity requires the experience and skills of a medical professional, it is reimbursed at 75%. All states claim to Medicaid for case management activities either as a medical assistance service or as an administrative activity. States may also be claiming both ways.

The FY 2007 Budget proposes to reimburse all case management activities, whether administration or medical assistance, at a 50% rate.

Case management activities are inherently the same, whether they are reimbursed as an administrative activity or as a medical assistance service. These activities assist Medicaid eligible individuals in gaining access to needed services. The existence of differing reimbursement rates, based on whether the activity is claimed as an administrative activity or as a medical assistance service, has resulted in states claiming services in the manner that results in the highest reimbursement for the state. The proposed change would remove the incentive to "shop around" for the highest reimbursement and would ensure that case management services are reimbursed in a cost effective and efficient manner.

22.
Question:
Medicaid: Your budget states that you will issue regulations that prohibit federal reimbursement to states and local school districts for transportation to health care services and other assistance they provide to children relating to health care services. What is the statute or regulation that gives you the authority to make this change?

Answer:
Appropriate Medicaid services, will continue to be reimbursed as allowed under current law. However, claiming for certain Medicaid services in school settings has proven to be prone to abuse and overpayments. Schools provide a wide range of medical services to students, which may or may not be reimbursable under the Medicaid program. The FY 2007 Budget proposes administrative actions to phase out Medicaid reimbursement for some services, including school bus transportation and administrative claiming related to Medicaid services provided in schools.

According to section 1903(a)(7) of the Social Security Act (the Act), for the costs of any activities to be allowable and reimbursable under Medicaid, these activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid State Plan). Additional authority derives from section 1902(a)(17) of the Act, which requires that states take into consideration available resources.

HHS has had long-standing concerns about improper billing by school districts for administrative costs and transportation services. Both the Department's Inspector General and the General Accountability Office (GAO) have identified these categories of expenses as susceptible to fraud and abuse. GAO found weak and inconsistent controls over the review and approval of claims for school-based administrative activities that create an environment in which inappropriate claims generated excessive Medicaid reimbursements. Audit findings from states where the OIG conducted administrative claiming audits have shown egregious violations. Proper and accurate claiming for administrative services has not been carried out in compliance with applicable Medicaid regulations. Overall, the leading conclusions from these audits are that most states use an improper allocation methodology and insufficient attention is paid to the details of the claiming process.

The President's 2007 Budget includes a regulatory proposal that would prohibit Federal Medicaid reimbursement for Medicaid administrative activities performed in schools. It additionally proposes that Federal Medicaid funds will no longer be available to pay for the transportation to and from school related to medical services provided through an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

Schools would continue to be reimbursed for direct Medicaid services identified in an IEP or IFSP provided to Medicaid eligible children, such as physical therapy and occupational therapy that are important to meet the needs of Medicaid-eligible students with disabilities, as long as the providers meet Medicaid provider qualifications.

23.
Question:
Medicaid: Your budget states that you will issue regulations to cap payments to public providers providing services under Medicaid. What is the statute or regulation that gives you the authority to make this change?

Answer:
The President's FY 2007 Budget includes a regulatory proposal to cap payments to government providers. The Federal government should limit its contribution to the amount of providing its share of the cost of providing services to Medicaid beneficiaries. Other health insurance payers limit the payments made on behalf of their covered lives to the costs of providing care to those individuals. Medicaid should do the same. The General Accountability Office (GAO) has repeatedly recommended that payments to government providers should not exceed the cost of providing the services.

Through the Medicaid State Plan Amendment (SPA) reimbursement review process, CMS discovered that several states make claims for Federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the guise of intergovernmental transfers (IGTs) states and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state, which effectively shifts the cost of the Medicaid program to the federal taxpayer.

While CMS has been successful in terminating such practices, most government providers that were required to return payments through the IGT process were returning the amount of the Medicaid payment in excess of cost. The Budget proposes to further improve the integrity of the Medicaid matching rate system by proposing steps to build on these past CMS efforts to curb financing abuses by capping payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries, a step recommended by GAO for several years.

Section 1902(a)(30)(A) of the Social Security Act (the Act), which requires that payments be "consistent with efficiency, economy and quality of care," requires the Secretary to protect against abuses by states and providers. We do not believe that the taxpayer should pay more to a public entity than it costs to deliver the service to a Medicaid beneficiary. Additional authority to protect the fiscal integrity of the program is also found at section 190(i)(3) and 1903(i)(17) of the Act.

24.
Question:
Medicaid: Your budget states that you will also issue regulations that restrict the services that states can provide under the category of rehabilitation services. What is the statute or regulation that gives you the authority to make this change?

Answer:
Rehabilitation services are an optional Medicaid service under Section 1905(a)(13) of the Social Security Act (Act) and defined at 42 CFR 440.130(d). Rehabilitative services are typically offered to individuals with special needs or disabilities to help improve their health and quality of life. Under current practices, states are billing Medicaid for rehabilitation services that are intrinsic elements of non-Medicaid programs. For example, CMS has determined that the costs of therapeutic foster care services, adoption services, family preservation and family unification services are being shifted by some states from foster care to Medicaid. Under the rubric of therapy support services, states are also shifting costs of non-medical support services and routine supervision provided by teacher's aides in school settings to Medicaid. Also, states are claiming for services that are not rehabilitative, which were previously approved by CMS as rehabilitation services.

All states provide rehabilitation services as an optional benefit in Medicaid. States can also provide rehabilitation services through home and community based services (HCBS) waivers, but the provision of such services through HCBS waivers would not be impacted by this proposal.

The FY 2007 Budget proposes to prevent cost shifting by issuing a regulation that would clearly define allowable services that may be claimed to Medicaid as rehabilitation services and exclude payment for rehabilitation services that are intrinsic to programs other than Medicaid. The regulatory change will also clarify that Medicaid payments will be available for rehabilitation services that are intended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

Through review of State Plan Amendments (SPAs), CMS has found that, by using overly broad definitions of rehabilitative services and payment methodologies that are not tied to specific covered services, states are bundling services together which Medicaid is not supposed to pay for at all, such as room and board. CMS has also found that these methods serve to effectively circumvent the statutory IMD exclusion, and the principle that Medicaid is the payer of last resort. To address these concerns, we find authority in a variety of places in title XIX of the Social Security Act, including sections 1902(a)(4)(A), 1902(a)(30)(A), section 1903(i)(17), and section 1905(a).

25.
Question:
SCHIP: Your budget proposes to shorten the timeframe for states to spend their SCHIP annual allotment from 3 to 2 years. What is the statute or regulation that gives you the authority to make this change?

Answer:
The President's FY 2007 Budget proposes legislation to address state shortfalls in FY 2007 that may occur for some states by seeking authority to better target SCHIP funds in a more timely fashion. The President's proposal is seeking legislative authority to make this change; it is not a regulatory change.

26.
Question:
Medicaid: What is your projected timeframe for the rulemaking outlined in your budget, both from the new provisions enacted in the Deficit Reduction Act of 2005 and the proposed regulatory changes?

Answer:
CMS is currently finalizing its work plan to meet all of the Deficit Reduction Act of 2005 deadlines and the proposed administrative changes in the President's FY 2007 Budget . CMS will be pleased to brief you when these work plans are finalized.

27.
Question:
Medicaid: Please provide greater detail on the grants for chronically ill individuals that your budget describes. Would this be administered through Medicaid? How would individuals receive access to health coverage through these grants?

Answer:
The President's FY 2007 Budget proposes providing $500 million per year to encourage states to test innovative methods for covering their chronically ill residents. The Secretary of Health and Human Services would award these grants through a competitive process. Legislative language addressing this proposal is under development.

Senator Hatch

1.
Question:
As you know, I am one of the few members of this Committee who serves on both the Finance Committee and the HELP Committee. I recognize the difficult decisions that you had to make regarding the FY07 budget for HHS and I commend you for putting forth a budget proposal for Congress may consider. I believe that you have placed the proper emphasis on which initiatives need to be prioritized – bioterrorism, community health centers and medical research are all important health care programs which should receive increased funding. However, I have to be honest with you. I am troubled by the proposed reductions in the President's budget for the Medicare and Medicaid programs. Could you please explain to me why the President believes that those reductions are necessary?

Answer:
The FY 2007 President's Budget includes a comprehensive, consumer-focused plan to address the problems of rising health care costs and the uninsured. The President's plan to reduce the rising cost of health care while improving quality and safety includes an emphasis on price transparency and disclosure of quality information. This plan also contains a package of proposals to promote:

- the use of health savings accounts (HSAs);
- grants to States to encourage innovations in providing coverage to chronically ill individuals;
- association health plans;
- medical liability reform; and
- a national marketplace for health insurance.

This administration is also promoting Health Information Technology, including electronic health records and e-prescribing, in order to improve quality of care and reduce costly errors. The Administration has also undertaken initiatives to improve care, reduce errors, and improve efficiency for beneficiaries by holding providers accountable for quality care. The Medicare website now displays quality data that allow consumers to make informed choices by comparing the performances of hospitals, skilled nursing facilities, home health agencies and dialysis facilities. Recently, CMS has expanded these efforts to include a voluntary reporting system for physicians.

In conjunction with steps to promote higher quality care, the Budget includes a set of Medicare proposals saving $2.5 billion in FY 2007 and $35.9 billion over five years. These proposals will implement productivity adjustments in provider payment updates; rationalize payments for certain covered services; expand Medicare Secondary Payer provisions; and extend competitive bidding to laboratory services.

The 2007 proposed legislation builds on Medicare changes in the Deficit Reduction Act of 2005 (DRA). DRA provisions support Administration priorities, such as using payments to support better performance and promoting quality improvement.

In conjunction with Medicare's recently updated benefits, which will promote more effective and prevention-oriented care, the FY 2007 Budget includes a package of Medicare legislative proposals which are necessary to strengthen the long-term financial security of the Medicare program. These proposals build on long-term Administration priorities for Medicare, such as improving quality and preventing medical errors, encouraging efficient and appropriate payment for services, fostering competition, and promoting beneficiary involvement in health care decisions. The net savings from this legislative package is $2.5 billion in FY 2007 and $35.9 billion over 5 years.

The Deficit Reduction Act of 2005 (DRA) takes important steps to reform Medicaid and SCHIP. These steps include preserving long-term care for those who need it most by eliminating abuses of asset transfers; reducing payments for Medicaid prescription drugs; giving States more flexibility with regard to program benefits, cost sharing and home and community-based services; and providing new funding sources for program integrity efforts.

The President's Budget includes legislative proposals to expand use of Medicaid benefits and only a limited number of savings proposals. The savings proposals are necessary to eliminate improper payments under the Medicaid and SCHIP programs and to pay more accurately for services provided under those programs while helping the uninsured, including a Cover the Kids initiative to find and enroll Medicaid and SCHIP eligible. SCHIP eligible children, and changes to Transitional Medical Assistance that will help families transition to work and retain health insurance coverage. Building on the DRA's progress, the Budget proposes Medicaid and SCHIP legislative changes that will save $1.3 billion over five years and administrative changes that will save $12.2 billion over five years.

2.
Question:
What are the administration's plans as far as CHIP reauthorization is concerned? As one of the original authors of the CHIP program, I intend to become very involved in the program's reauthorization. At the appropriate time, I would like to sit down with you and your staff to talk about this in more detail.

Answer:
The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997, P.L. 105-33, which created Title XXI of the Social Security Act. Title XXI appropriated $40 billion, in the form of allotments, over 10 years, beginning in FY 1998 through FY 2007. The FY 2007 President's Budget estimates $5.2 billion in SCHIP outlays for FY 2007. Projected outlays in the five-year period FY 2007 through FY 2011 are $32.2 billion. FY 2007 is SCHIP's final year of authorization. Re-authorization is assumed in the baseline.

In addition, the President's budget proposes to address state shortfalls in FY 2007 that occur for some states by seeking the authority to better target SCHIP funds in a more timely manner by changing the SCHIP allotment period of availability from three to two years.

We would be happy to work with you and your staff about the program's reauthorization.

3.
Question:
One program that is not under the jurisdiction of the Senate Finance Committee is the cord blood legislation that was signed into law last December. Could you please explain what the President's budget does as far as this program is concerned? I have been a strong advocate of this program and was pleased that the President has been so supportive of this bipartisan legislation. However, there is more work to be done and that work requires sufficient federal dollars. It is my hope that your agency, especially HRSA, will work with me to get this new program up and running as quickly as possible.

Answer:

The Administration is committed to the National Cord Blood Stem Cell Program. The lack of a request for new funds for this program is based on the strong belief that sufficient funds are and will be available for this program at this stage. A balance of $18 million remains from appropriations made in FYs 2004, 2005, and 2006. HRSA will use these funds to implement the program during FY 2006 and FY 2007. Specifically, in each of these fiscal years, approximately $9million of the remaining balance will be used toward the implementation of the program and the collection of an estimated total 13,800 new cord blood units. HRSA is committed to working with Congress as they begin to implement this important new program.

4.
Question:
Secretary Leavitt, as a result of the FY 2006 Deficit Reduction Act, a large segment of imaging reimbursement will now be based on an entirely different payment methodology. Section 5102(b) of the law reimburses one particular service differently than other physician services. In your opinion, could this action make the resource-based relative value scale ("RBRVS") system obsolete in determining the payment schedule for all physician services? Do you think moving from the Medicare physician fee schedule to paying physicians under a hospital outpatient prospective payment system is appropriate?

Answer:
Currently, Medicare pays physicians significantly larger amounts than hospital outpatient departments (OPDs) for the same service for certain imaging services. During the past few years, there has been very rapid growth in Medicare spending for imaging services paid under the physician fee schedule. MedPAC has identified site neutral payments for the same service as a long term goal under Medicare fee-for-service payment systems. MedPAC has also raised the issues about the equipment utilization assumptions used in establishing the relative values for imaging services under the physician fee schedule which mean that Medicare payments for such services are too high. However, data for procedure and equipment specific information on alternative equipment utilization assumptions has not been identified. In the context of all these points, section 5102(b) of the Deficit Reduction Act of 2005 establishes a payment limit for the technical component of imaging services. The provision requires that Medicare not pay a physician more than Medicare would pay the OPD for furnishing the same imaging procedure. A physician's interpretation of the test for which Medicare will pay a separate fee is not affected by the provision. It is appropriate policy for Medicare to limit excessive physician fee schedule payments for imaging procedures to the OPD payment rate for the same imaging procedure to promote consistent payment policy across settings. I do not believe this policy makes the relative value scale and physician fee schedule obsolete.

5.
Question:
Secretary Leavitt, poor access to quality health care may also be an unintended consequence of section 5102(b) of the Deficit Reduction Act. As you may know, capping all in-office imaging at the lesser of the Medicare physician fee schedule or the hospital outpatient rate could result in reductions of up to 75% for some procedures and 50% for other more critical procedures, such as MRI of the brain and MRI of the lumbar spine. I am worried that physicians and imaging centers may be unable to withstand such drastic reductions and, as a result, stop practicing medicine. It is possible that patients only be able to go to the hospital in order to receive these medical services. What is your opinion about providing diagnostic imaging services in the hospital setting? Could this have an impact in rural or medically underserved communities?

Answer:
In 2006 Medicare is paying a physician $903 for doing an MRI of the brain or an MRI of the abdomen. Medicare pays a Hospital Outpatient Department (OPD) $506 for the exact same test. Thus, Medicare is paying almost $400 or 78 percent more for doing MRI tests in a physician's office (rather than an OPD). Similarly, Medicare will pay 267 percent more for doing an ultrasound guidance for artery repair in a physician's office than in an OPD ($228 vs. $62). These comparisons do not include a physician's interpretation of the test for which Medicare will pay a separate fee. There is no consistency in the

percentage that the physician fee schedule exceeds the hospital OPD payment amount. The percentage difference varies by procedure.

During the past few years, there has been very rapid growth in Medicare spending for imaging services paid under the physician fee schedule. MedPAC has identified site neutral payments for the same service as a long term goal under Medicare fee-for-service payment systems. MedPAC has also raised the issues about the equipment utilization assumptions used in establishing the relative values for imaging services under the physician fee schedule which mean that Medicare payments for such services are too high. However, data for procedure and equipment specific information on alternative equipment utilization assumptions has not been identified. In the context of all these points, section 5102(b) of the Deficit Reduction Act of 2005 establishes a payment limit for the technical component of imaging services. The provision requires that Medicare pay a physician no more than Medicare would pay the OPD for furnishing the same imaging procedure. A physician's interpretation of the test for which Medicare will pay a separate fee is not affected by the provision. It is appropriate policy for Medicare to limit excessive physician fee schedule payments for imaging procedures to the OPD payment rate for the same imaging procedure to promote consistent payment policy across settings. I do not believe this policy makes the relative value scale and physician fee schedule obsolete.

It is hard to justify paying physicians more than Medicare pays OPDs for furnishing the same imaging service. This step to level the playing field between physicians' offices and hospital OPDs only applies to procedures where Medicare pays more in physicians' offices; the DRA cap provision does not apply to all imaging procedures furnished in physicians' offices. In addition, the percent that Medicare payment rates for physicians' offices exceeds OPDs are not all as large as the examples cited above; in numerous cases, the differential is 10 to 20 percent. Thus, the overall impact is not expected to be as dramatic as in the examples above. I do not believe that physicians' offices or imaging centers will stop practicing medicine or that beneficiary access would be limited to OPDs. Nor do I believe that the provision would have an impact in rural or medically underserved communities.

6.
Question:
Has HHS conducted any analysis on the ability of a physician's office or imaging centers to continue to offer imaging services, such as mammography? What could happen if the only option for mammography patients is to receive these services in the hospital setting? Could this change impact a woman's timely access to these important services?

Answer:
Screening and diagnostic mammography procedures would not be impacted by the provision in the Deficit Reduction Act of 2005 (DRA). Prior to the DRA, the Medicare statute required that payment amounts for both screening and diagnostic mammography services be the same in both physicians' offices and hospital outpatient departments. The DRA does not change that policy. Thus, this provision would have no impact on a woman's timely access to these important services.

7.
Question:
Secretary Leavitt, thank you and CMS Administrator McClellan for working with me on the gainsharing demonstration project in Section 5007 of the FY 2006 Deficit Reduction Act. Both of your efforts were greatly appreciated by me. Your staff has promised to keep my office apprised of your department's efforts to create this demonstration project. In addition, I am deeply interested in the details on how it will be implemented and, upon its completion; I want to review the department's final recommendation regarding gainsharing.

As you know, this is an important issue for device manufacturers throughout Utah and across the country – I want to make sure that HHS will continue to pay close attention to the Office of Inspector General's safeguards that have been required on all gainsharing arrangements approved by HHS. In addition, my understanding is that the gainsharing demonstration project will be limited to six hospitals. Is that still the case? Again, thank you for all of your assistance with this important matter.

Answer:
The Department is interested in options that would encourage greater coordination and collaboration between hospitals and physicians. We believe that these options could result in better quality of care and greater efficiency. If gainsharing is permitted as part of the original Medicare program, we believe that it should have certain safeguards to ensure that it does not somehow encourage a reduction in needed care. Some such safeguards include requiring participating hospitals to report on their quality of care and to maintain good care quality, and limiting the size of the incentive payments to physicians so that the payments are not so large as to encourage reductions in needed care. This would be similar to the Physician Incentive Payment limitations to gainsharing payments in the Medicare Advantage program.

Section 5007 of the Deficit Reduction Act of 2005 directs the Secretary to establish a demonstration program by November 1, 2006 to test and evaluate methodologies and arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to Medicare beneficiaries. The provision requires that the program be conducted for 3 years—from January 1, 2007 through December 31, 2009. Within 90 days of enactment, we must solicit applications for approval of demonstration projects under the program. The provision limits the program to no more than 6 projects, at least 2 of which must be located in a rural area.

CMS takes a broad view regarding the demonstration program, focusing not on short term cost savings through the initial hospital stay but instead on lowering the overall costs of an entire episode of care, minimizing health care complications for beneficiaries, and improving patient outcomes. CMS intends to conduct a limited number of gainsharing demonstration projects of limited length to study the overall costs of an episode of care, which spans hospital and post acute care settings. We are looking forward to implementing this demonstration program as a way to improve the quality and efficiency of care provided to Medicare beneficiaries, and I look forward to working with the Office of the Inspector General, as well as Congress to ensure that gainsharing arrangements promote the best possible outcomes.

8.
Question:
Mr. Secretary, I recently received the letter below from the President and CEO of the National Association of Chain Drug Stores. I would be interested in any comments you have regarding this letter.

February 8, 2006

The Honorable Orrin Hatch
Member, Committee on Finance
United States Senate
Washington, D.C. 20510

Subject: Additional Proposed Medicaid Generic Drug Payment Cuts in FY 07 Federal Budget

Dear Senator Hatch:

We wanted to make you aware of a proposal in the President's FY 07 HHS budget that would further reduce Medicaid payments for generic medications dispensed by retail pharmacies by $1.29 billion federal dollars – or $2.2 billion total dollars – over the 2007-2011 federal budget period. To do this, the budget proposes to lower the Federal Upper Limit (FUL) for generic drugs from 250% of the lowest Average Manufacturers Price (AMP) to 150% of AMP.

It is extremely troubling to us that HHS would propose these additional cuts to pharmacies for generic medications when the changes made to the FUL in the recently-passed Deficit Reduction Act (DRA) are estimated to take a total of $6.3 billion in Federal and state dollars out of retail pharmacy payments over the 2006 to 2010 Federal budget period. When combined, these two cuts will take more than $10 billion out of retail pharmacy payments through 2011.

We opposed the Medicaid pharmacy payment reductions that were eventually enacted in DRA. This is because we believed then, as we believe now, that these reductions would reduce generic dispensing in Medicaid, which would ultimately increase costs to Medicaid. We believe that these further proposed reductions would only exacerbate this situation, and even further shift the burden to states to increase dispensing fees to maintain generic dispensing incentives.

Having said that, we are especially troubled that these proposed reductions are being made on top of widespread reports – of which HHS and the Congress are fully aware – that pharmacies have been laboring mightily under the administrative and financial burdens of implementing Medicare Part D. Pharmacies have spent countless uncompensated hours over the past six weeks making every effort to ensure that the Part D program is working for CMS, plans, and most importantly, Medicare beneficiaries.

As a result, we do not believe that this budget proposal is worthy of the extraordinary efforts made by retail pharmacies to help get the Part D program up and running, or the financial burden and costs that they have had to incur to do so. Yet, community retail pharmacies are now being asked to endure billions of dollars in additional cuts from Medicaid generic drug payments that will further erode their already precarious financial situation.

We will ask every Member of Congress to take a pledge to vote against any bill that includes any direct or indirect additional further cuts to Medicaid retail pharmacy reimbursement. In addition, we ask that you request HHS to further explain and justify their rationale for these proposed pharmacy cuts given the critical role that pharmacists have played in the implementation of Part D. We appreciate your consideration of this request. Thank you.

Best regards,

Craig L. Fuller

Answer:
The Centers for Medicare & Medicaid Services is committed to helping states reduce Medicaid drug costs. As part of a commitment to reduce drug costs, CMS actively encourages the use of generic alternatives in place of brand name products. This is partly achieved through the use of the Federal Upper Limit (FUL), a program that sets limits on what State Medicaid program can pay for brand name drugs that have therapeutically equivalent generic medications. The FUL program is intended to assure that the Federal government acts as a prudent buyer of drugs. The concept of the upper limits program is to achieve savings by taking advantage of the current market prices.

Under prior law, the FUL was set at 150% of the price of the lowest cost drug in the category as reported in published drug pricing compendia. Over time, the FUL was increasingly less effective in assuring that the Medicaid program paid appropriately for multiple-source drugs. This fact has been documented by studies by the Inspector General for the Department of Health and Human Services, by the bi-partisan Medicaid Commission, and in testimony before House Energy and Commerce Committee. Over time, these reported prices have become less reliable as estimates of the true acquisition cost of drugs.

The DRA revised the way in which the FUL is calculated by changing the reference point for the FUL calculation from prices published in pricing compendia to the Average Manufacturer Price (AMP) and set the FUL for multiple source drugs was 250% of the lowest cost product among the therapeutically equivalent products.

The Budget proposal builds on DRA changes to the Federal upper limit for multiple source drugs by limiting reimbursement for multiple source drugs to 150 percent of the AMP. This will continue efforts to further reduce Medicaid overpayments for prescription drugs. States would have the flexibility to support innovative approaches to lower drug costs, such as paying pharmacists more when they help patients use less expensive generic drugs.

The FUL, which set for each drug, may be exceeded by States for selected drugs if the State offsets this added cost by reducing payments for other FUL drugs. Because the limit is applied in the aggregate, States have flexibility to raise the prices paid for certain drugs to address supply issues in the State or pay more to categories of pharmacies (eg. Small independents that may be required to pay higher wholesale prices).

The President believes that flexibility is essential to ensure that the States have adequate tools to set appropriate payment rates and worked hard to ensure that this feature was retained in the new law.

It is also important to mot that States may pay pharmacies higher prices for brand name drugs subject to the FUL if a physician attests that the brand drug is medically necessary for the patient.

Senator Snowe

1.
Question:
Part D Benefit – Low Income Subsidy: Of the approximately 3.6 million beneficiaries who have enrolled on their own in Part D coverage – who were not auto-enrolled in some fashion – only a very small fraction have been found eligible for the low income subsidy. It is unclear how much the application process may be impeding some from obtaining assistance, compared to disqualification of their submitted application.

I understand that a variety of factors can disqualify seniors from low income assistance. One concern is that a relatively limited amount of assets could prevent those with low disposable incomes from obtaining assistance which could help them maintain their health and prevent unnecessary hospitalizations and nursing home care.

One of the great benefits of prescription drug coverage is reducing hospitalization and disability. Thus it is crucial that we examine why so few seniors are receiving the additional low income assistance.

First, could you describe what efforts HHS is making to improve outreach efforts to low income individuals and to simplify the application process?

Second, in light of the low proportion of seniors actively enrolling who are qualifying for a low income subsidy, and the data you have seen thus far on applications for assistance, what factors do you believe are contributing to the high rejection rate for applications for low income assistance? Particularly, how much and what kind of assets are disqualifying seniors from low income assistance?

Answer:
The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, making prescription drug coverage available to all Medicare beneficiaries. The MMA also provides extra help in the form of a low-income subsidy, with prescription drug costs for eligible individuals whose income and resources are limited. The new law requires both the Social Security Administration (SSA) and the States to accept and process applications for the low-income subsidy (LIS).

Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy and do not have to apply. The following groups are deemed eligible: full-benefit dual eligibles (FBDEs) who are persons eligible for both Medicare and full Medicaid benefits; supplemental Security Income (SSI) recipients, including SSI recipients who receive a cash benefit but not Medicaid; and Medicare beneficiaries who are participants in the Medicare Saving Programs (MSP), which are QMB, SLMB, and

QI. Deemed eligibles do not need to file an application for the subsidy. All others wishing to receive extra help must apply for the subsidy.

A simplified application form and process for determination and verification of an eligible beneficiary's income and resources for purposes of the Medicare Prescription Drug benefit has been developed by SSA and will be available for on-line, mail, in-person, and phone filing. SSA has mailed these applications to 19 million potentially eligible people with Medicare in May through August of 2005.

While SSA has primary responsibility for processing LIS applications, CMS is committed to ensuring that beneficiaries can take advantage of the extra help that is provided through the LIS. CMS is actively engaged in a comprehensive outreach campaign to encourage potentially eligible people with Medicare to apply for the extra help. Outreach strategies include community events, and partnering with stakeholders such as States and community-based organizations as well as the Access to Benefits Coalition. CMS currently works with many national, regional, state, and local partnership communities including the following:

- Advocacy organizations and coalitions
- Caregiver organizations and coalitions
- Disability organizations and coalitions
- Employer and union organizations and coalitions
- Faith-Based organizations and coalitions
- Federal and State organizations and coalitions
- Health organizations and coalitions
- National Medicare Education Program Partnerships
- Pharmacy organizations and workgroups
- Provider organizations and coalitions
- Racial, ethnic, and cultural organizations and coalitions
- Rural Health organizations and coalitions
- State Health Insurance Programs (SHIPs)

CMS feels confident that working with our partners is a key to helping people with Medicare maximize their benefits and improve the health and wellness of seniors, and people with disabilities.

Regarding your question about rejection rates for the low income subsidy, the Social Security Administration is responsible for processing LIS application and has the data on the disposition of the low-income subsidy applications.

2.
Question:
Graduate Medical Education Payments in Non-Hospital Settings: Since 2002, graduate medical education (GME) programs in Maine and across the country have experienced financial and operational difficulties as a result of regulations issued by the Centers for Medicare and Medicaid Services (CMS) regarding the use of non-hospital teaching sites in their GME programs. The issue concerns a lack of clarity in existing CMS regulations and guidance regarding the compensation of teaching time in these community settings.

Many medical residency training programs have traditionally operated in sites located outside the hospital setting for their educational programs. These "non-hospital" settings are, in fact, where most of this type of physician training occurs. The community and rural sites which operate these programs include physician offices, nursing homes, and community health centers – cornerstones of ambulatory training for graduate medical education (GME) programs. These programs often rely upon volunteer physician faculty to provide educational opportunities in practice settings which are similar to those in which these physicians in training will ultimately practice.

Congress clearly stated support for this concept as part of the Balanced Budget Act of 1997 (BBA) when they reformed the GME funding formulas to allow funding for residents training in non-hospital settings in

the community which resemble those in which they will ultimately practice. The GME payments were revised to encourage more ambulatory training programs by allowing teaching hospitals to count the time residents spend in such settings towards their indirect medical education (IME) reimbursements. This is especially important for primary care residency programs since most primary care physicians practice in the community rather than within a hospital setting. Hospitals have been able to include such time for the purposes of direct GME payments since 1986.

Since 2002, CMS fiscal intermediaries have disallowed much of this time in reviewing IME payments, and in many cases, have audited programs and demanded repayment for the time these residents spent in non-hospital settings. These actions are creating a chilling effect on medical residency training programs. Teaching programs across the nation are facing audits and scrutiny as a result of confusing and unclear CMS policies and guidance. This has happened in my state, as well as many others, and is posing a serious threat to our future physician workforce and to teaching hospitals and medical schools which offer these programs. Teaching programs in Maine have been required to repay hundreds of thousands of dollars as a result of these audits. These audits not only jeopardize the financial stability of the teaching hospital, they also threaten the very existence of these residency programs.

Teaching programs are also losing available residency slots as a direct result of the flawed regulations associated with non-hospital training sites. For example, as a direct result of recent CMS actions, one teaching program run by the University of New England has estimated that they lost funding for 3.48 full time employee (FTE) residency slots in 2004, and they project the loss of funding for 2.58 FTEs in 2005 and 5.25 FTEs in 2006. Maine is a small state that relies upon the few residency programs we have to train and ultimately fulfill much of our state's physician workforce needs.

The current application of this regulation is resulting in fewer physicians being trained in our state. If these agency policies are not halted and reversed, teaching hospitals throughout the country will be forced to train all residents in the hospital setting or potentially eliminate their residency programs. Not only does this do a disservice to medical residents who are able to obtain practical experience and be exposed to settings where they are likely to practice, but discontinuing these programs would have adverse consequences on surrounding communities and rural areas which rely on these residents to provide health care which might not otherwise be available in medically underserved areas of the state.

Unfortunately, the issue of GME payments has become a semantic debate about the meaning of a few words, "all or substantially all of the costs." The CMS interpretation of this phrase is causing my state to lose significant training opportunities for physicians and threatening the future viability of these programs.

Given the congressional intent of this provision and the damage that is being done to quality education and the future physician workforce, shouldn't the hospital and supervising entity be allowed to continue to determine their level of supervisory costs, if any, rather than having to follow government directives which shed no clarity on the situation?

Training medical residents outside the hospital setting is sound educational policy and a worthwhile public policy goal that Congress clearly mandated in 1997. It is my sincere desire to work with you and CMS resolve this issue, but I am prepared to pursue legislation if needed. I have therefore introduced a bill with several of my Senate colleagues, the Community and Medical Residency Preservation Act of 2005, to clarify that teaching hospitals and non-hospital teaching sites should be allowed to determine the appropriate compensation, if any, for teaching services.

You stated last year that you are doing everything you can under the statute to facilitate the use of volunteer faculty. Given this position, what steps are you taking to ensure that teaching hospitals and non-hospital teaching sites are allowed to determine the appropriate compensation for teaching services?

Answer:
I share your commitment to and recognize the value of training medical residents outside the hospital setting. With recent technological advances, as well as an increasing need for high quality medical care in

rural and underserved areas, the delivery of medical care is shifting more and more to clinics and offices outside the hospital, making training in such settings even more important.

As you know, the Medicare program contributes to the training of physicians across the country by compensating hospitals for the direct and indirect costs incurred in training medical residents, whether such training occurs in the hospital or in a non-hospital setting (e.g., a clinic, physician's office, nursing home, community health center, etc.). Direct graduate medical education (DGME) payments are made to teaching hospitals to help cover the direct costs of training residents, including residents' salaries and fringe benefits, and a portion of the teaching physicians' salaries and fringe benefits. Indirect medical education (IME) payments are added on to a hospital's inpatient payments to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals.

In fiscal year 2006, Medicare is projected to pay hospitals more than $8 billion in graduate medical education payments. Because these payments are made to the hospital whether the training occurs in the hospital or outside the hospital, identification of the training costs and the entity bearing such costs is critical. Such identification, especially with regard to training occurring outside the hospital, is essential to ensure that hospitals are not overpaid and that non-hospital sites are appropriately compensated by the hospital for the costs they incur in training medical residents.

As you stated in your question, the Social Security Act recognizes this by requiring that hospitals incur "all or substantially all" of the costs for the training in the non-hospital setting in order to count the medical resident training at the non-hospital site in their full-time equivalent (FTE) count and receive Medicare graduate medical education payments for that resident. Medicare regulations define "all or substantially all" of the training costs to include (in addition to the residents' salaries and fringe benefits) the portion of the cost of teaching physicians' salaries and fringe benefits attributable to the training of the residents.

Recently, questions have been raised regarding the interaction of this policy and the ability of physicians in non-hospital sites to supervise residents on a volunteer basis. Volunteer teaching physicians are an important resource for graduate medical education programs, especially in non-hospital settings. Volunteerism is certainly encouraged under the Medicare program, and we are doing everything we can under the statute to facilitate the use of volunteer faculty. In fact, we clarified that in cases where there are truly no costs incurred by the non-hospital site for the teaching physician's services, the hospital is not required to pay for the teaching physician's time in order to count and receive Medicare payment for the residents training in the non-hospital site. However, where there is a cost to the non-hospital site, the statute clearly requires that the hospital must incur "all or substantially all" of that cost in order to receive Medicare graduate medical education payments for those residents. We do not believe Congress intended that hospitals should continue to receive Medicare graduate medical education payments related to training furnished outside the hospital without incurring the costs associated with such training. To have a community clinic or local physician's office cover the costs of training at their site while the hospital receives IME payments for such training (a payment for treating *hospital inpatients)* would be inequitable, illogical, and would undermine the goal of promoting and supporting these community and rural sites.

You suggested that hospitals and non-hospital sites should be able to determine what costs, if any, the hospital should pay for supervisory activities. Medicare regulations do allow hospitals and non-hospital sites to enter into written agreements regarding supervisory costs. However, these regulations require that the agreed-upon compensation be "reasonable." "Reasonable" compensation cannot be provided by the hospital to the non-hospital site without a determination of what the non-hospital site's costs actually are. These requirements serve to protect the non-hospital site and ensure that the compensation agreed upon is adequate. An agreement between the hospital and non-hospital site that has no relationship to actual costs incurred is contrary to the statutory requirement that the hospital incur "all or substantially all" of the costs and, most importantly, fails to recognize the valuable contributions to resident training made by non-hospital sites.

I applaud your commitment to the community and rural sites in Maine and across the country that are furnishing valuable training to medical residents. As you mention in your question, by allowing hospitals to receive IME payments, in addition to DGME payments, for non-hospital training, the intent of the

Balanced Budget Act (BBA) provision was to promote such training with the goal of increasing the number of medical residents—and ultimately practicing physicians—in rural and underserved areas. Despite the significant amount of Medicare funding used to support such training programs since the BBA, we have not yet seen any appreciable increase in the number of residents training outside of the hospital. I look forward to continuing to work with you to encourage increased resident training in non-hospital settings, while ensuring that Medicare payment policies continue to recognize and support the significant contributions to resident training made by community and rural sites.

Senator Kyl

1.
Question:
CMS: We are spending the most money in CMS, $597 billion, an increase of $15 billion from fiscal year 2006. The budget calls for a series of reductions in payment to facilities – hospitals, skilled nursing homes, home health, hospice – and simultaneously seeks to innovate with "health IT" and initiatives that seek to improve quality. I too want to achieve both of your objectives, to decrease costs and to have a more efficient system, but I am concerned we may be in for a roller coaster ride of increases and decreases that leave providers unsure of how to plan for future capital upgrades. Not all facilities will be able to sustain these reductions in the same way – smaller facilities, teaching facilities, urban and rural facilities may experience anticipated reductions differently.

What are your thoughts to moving to a straightforward reimbursement policy that pays appropriately instead of the current atmosphere where we are annually determining payment amounts (some would argue setting or controlling prices) that may not support the kind of innovation and quality efforts we desperately need in healthcare?

Answer:
The current Medicare payment systems do not provide incentives for providers to take into account all of the services furnished to beneficiaries during an episode of care, or furnished during a period of time to treat chronic disease. This often has the effect of directing more resources to delivering care that is not of the highest quality (for example, duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications). Conversely, providers who have good ideas and want to take action to improve quality of care find that Medicare's payment systems do not provide them with the resources or the flexibility needed to do so. As a result, providers are unable to invest in activities that, properly implemented, have the potential to improve quality and avoid unnecessary medical costs.

Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that result in improvements in the value of care that our beneficiaries receive. The Administration supports provider payment reforms that would encourage quality and efficiency, and discourage increased complications and costs.

The President's Budget indicates support for linking quality to Medicare payment in a cost neutral manner. We believe that savings from reducing care that is unnecessary or otherwise inappropriate affords opportunities to fund incentive payments. We believe we should examine possibilities of improving care coordination and using some of the savings generated in one payment system to fund incentives in another, as long as these reforms do not provide inappropriate incentives to deny necessary care.

2.
Question:
My state has been an innovator in the area of Medicaid. Arizona has had a 1115 waiver since 1982 that has been quite different from other states. Our Medicaid product stresses managed care and has included prescription drugs and long term care in its arrangement with its plans. This was a novel concept years ago and frankly, I am surprised that more states have not attempted to find savings from such a model. I

understand that Arizona has saved CMS close to half a billion dollars since its inception because of our unique model.

I also know from my conversations with the Governor's office and my staff that you, Mr. Secretary, and your staff have been very responsive to questions we have had – on Part D, on the future of the 1115 waiver for long term care facilities and acute care.

How can we encourage or incentivize states to innovate and to develop more cost-effective programs? What kind of measures will CMS take to move states to become more efficient and to discourage states from drawing on the federal match in excess?

Answer:
Building on the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative and approaches adopted by innovative states such as Florida, the Administration will develop a new waiver initiative that emphasizes market-driven approaches to health care. In conjunction with the Deficit Reduction Act of 2005 (DRA), this approach allows states to emphasize expanding needed coverage to uninsured individuals and to promote greater continuity of coverage. This new model will stress consumer-driven approaches to health care with access to affordable coverage while giving states more tools to offer better health coverage to some current beneficiaries, as well as to individuals who are currently uninsured. By broadening choices and encouraging competition in the private market, Medicaid can continue to modernize through state-level reforms. The result will be more seamless access to coverage for low-income families and children in Medicaid, as well as to other uninsured persons with limited incomes.

While further details of this new initiative are being developed, this new model for demonstration initiatives will build upon past CMS and state successes with initiatives that include public-private partnerships, consumer and market-driven health care, tax credits, high-risk pools and premium assistance. HIFA demonstrations, which began in the fall of 2001, have allowed states to provide health care to more beneficiaries with the same amount of funding by changing delivery systems, redirecting current health care dollars to provide expanded coverage, and working with employers to ensure that employer-sponsored insurance (ESI) options remain available, and are in fact expanded. As of November 2005, over 800,000 individuals are eligible to receive health insurance coverage through HIFA demonstrations. The Administration hopes to increase this number by providing even more options to states for demonstrations to offer better health coverage to current beneficiaries as well as to expand coverage to the uninsured.

CMS will be making sure it gives states the options and tools they need to stay on the forefront of twenty-first century innovations in health care delivery and financing. Even since the recent implementation of the HIFA demonstrations, there have been additional innovations in the health care market through increased consumer information and decision-making, emphasis on personal responsibility and health care efficacy, and chronic care management coupled with technology. These developments allow new options that can benefit Medicaid and SCHIP enrollees. Consumer-driven options, along with other integrated market driven efforts, create opportunities for states to leverage this new flexibility to realign and reorganize their resources and funding streams to promote private market health coverage solutions through public/private partnerships and other approaches. Specific strategies could include ESI subsides in lieu of enrollment in Medicaid/SCHIP, Health Savings Account (HSA) and other incentive-based program features, Deficit Reduction Act (DRA) benefit flexibility, tax credits, transformation of categorical eligibility to income-based, and the collective power of coalescing divergent funding to encompass a greater share of low income working individuals and families.

Through approaches like these we propose to limit unsustainable increases in our health care spending through initiatives that will inject consumer involvement back into the health care system.

3.
Question:
The Medicare Trustees determined that Part A is going to be insolvent in 2020. That date will come soon enough and if we don't do something proactive, the problem will persist and perhaps get even worse. What concrete efforts do you think we can undertake to sure up the solvency of the Part A program?

Answer:
Controlling health care costs is key to strengthening the long-term fiscal sustainability of the Medicare Part A Program. According to the 2005 Medicare Trustees' Report, reducing the projected growth in per beneficiary health care costs by one percentage point would reduce the 75-year actuarial imbalance for the Hospital Insurance (HI) program by two-thirds.

The Administration is addressing the issue of rising health care costs by creating Health Savings Accounts (HSAs) and Association Health Plans to increase the affordability and availability of health insurance for small-business owners and their employees, modernizing medical technology with new investments in health information technology, and examining ways to further develop and introduce enhanced methods of payment into the original Medicare program to improve the quality and value of care delivered to Medicare beneficiaries.

The current payment system does not provide incentives for providers to take into account all of the services furnished to beneficiaries during an episode of care, or furnished during a period of time to treat chronic disease. This often has the effect of directing more resources to delivering care that is not of the highest quality (for example, duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications). Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that result in improvements in the value of care that our beneficiaries receive. The Administration supports greater availability of reliable and consistent quality information through incentives for quality reporting, as well as provider payment reforms that would encourage performance improvement on quality and efficiency measures and discourage increased complications and costs.

The Medicare Modernization Act of 2003 (MMA) contains some important steps toward addressing rising health care costs for seniors. In addition to providing prescription drug coverage, it also brings up-to-date preventive benefits and programs to prevent complications for beneficiaries with chronic illnesses. These benefits will help Medicare and its beneficiaries avoid costs associated with preventable disease complications. In addition, the law requires that the Trustees determine whether the difference between Medicare spending and dedicated financing sources exceeds 45 percent of Medicare outlays within the following seven years, triggering the development and consideration of fast-track legislation to address excess Medicare costs. The provision highlights the importance of modernizing Medicare now and taking the cost-saving steps included in the MMA to provide a strong foundation for any further efforts to address Medicare costs.

4.
Question:
While not mentioned in the President's budget as an area of cuts, I remain very concerned about physician payment. The SGR has been a problem for the Administration, for the Senate and House, for physicians and importantly, for the patients who are left to wonder if their physicians will accept Medicare, new patients, or continue to practice medicine at all. Can I get a commitment from you to work with me and my colleagues on a permanent fix to physician payment?

Answer:
The Deficit Reduction Act (DRA) of 2005 eliminated the negative physician update that would otherwise have taken place for 2006. In 2006, the physician community is developing quality measures that would cover a broad group of physician specialties and a wide range of clinical areas for physicians to begin reporting in 2007. We are working closely with the physician community to develop these evidence-based quality measures. During 2006, we are conducting a physician voluntary reporting program to allow physicians to report some existing quality measures and to allow us to test administrative mechanisms for reporting such measures. We are also examining the administrative issues that would be involved with alternative mechanisms to reward physicians who report information on quality measures. As the year transpires, we will assess progress in the development of performance measures for physicians, as well as mechanisms for the reporting of measures in 2007. This will provide physicians with the opportunity to report measures first, leading to payment for reporting and performance on such measures in the future.

We would be happy to work with you and your colleagues on the physician update issue for 2007 and future years.

5.
Question:
Food And Drug Administration (FDA) I have been very concerned about the FDA over the last 2 years…the agency operated with an interim Administrator for too long, and once a permanent Administrator was in place, the position was vacated only a few (2) months later. This is problematic, because the FDA has serious responsibilities as well as serious challenges. The agency is responsible for our food and the life-saving medications that allow so many to live longer, healthier lives.

I often explain the rationale for not allowing importation because the FDA is the 'gold standard' of drug testing and drug review. We must maintain that high standard by having competent people at the FDA with the necessary resources to do their jobs and who are able to make the appropriate, scientific decisions without a fear of pressure to arrive at decisions that favor the drug industry or compromise public safety in any way.

I also hear about backlogs at FDA and concerns about the timeliness of reviews and decisions. The budget for the Office of Drug Safety was increased by only $4 million to $39 million. Is this amount sufficient for the task? I would like specifics on the number of people employed in that office, the number of new drug applications it reviewed last year, and the office's backlog, if any.

Answer:
FDA's Office of Drug Safety within the Center for Drug Evaluation and Research (CDER) does not manage the new drug review process. That function is managed by CDER's Office of New Drugs (OND). Currently, the OND staff are managing the review workload within the timelines and targets set forth by the Prescription Drug User Fee Act (PDUFA). OND is not experiencing a backlog in our review of these applications. In the new drug review process, Office of Drug Safety personnel act as consultants to OND staff as they evaluate safety profiles of marketed drug products, provide consults on risk management programs, communicate drug risk information to health care professionals and patients directly via MedWatch, review patient-directed documents to improve the use of patient-friendly language, and reduce medication errors by providing expertise on improving drug packaging and labeling and proprietary drug names. Additional funding for risk management activities from PDUFA fees has enabled FDA to increase its public health and consumer protection efforts in overseeing the safety of newly-approved drug products during their first two or three years on the market. This funding, as well as additional appropriated resources in FY 2006, makes it possible for FDA to increase the number of staff responsible for evaluating the safety profiles of marketed drug products. FDA has been able to hire more scientists, including epidemiologists, drug utilization specialists, and safety evaluators in the last few years. The planned increase for CDER for the Drug Safety program in FY 2007 is $3.56M, and just over $3M of those funds are planned for the Office of Drug Safety. These funds will enable the Office to sustain its current staffing levels as well as hire additional scientists. Currently, there are 106 people employed in the Office of Drug Safety.

6.
Question:
NIH Related to the allocation of funding in NIH, we see that the National Cancer Institute has the largest budget, $4.754 billion, followed by the National Institute of Allergy and Infectious Diseases ($4.395 billion) and then the National Heart, Lung and Blood Institute ($2.9 billion). One might assume that we put money in the areas that affect the largest number of people or have the most deaths. Can you provide the general rationale on the distribution of NIH funds? Is the science and the research as well as the incidence of diseases considered when developing the NIH budget?

Answer:
There is no simple formula that can be or is used to set NIH spending priorities. In any one year and over the long-run in deciding how and where to distribute the IC budget allocations, NIH leadership must take into consideration a number of important factors, e.g., burden of disease, the balance between basic and

clinical research, the emergence of new medical problems, and new scientific opportunities. There are many ways of assessing public health needs and many facets to identifying, and sometimes creating, scientific opportunities.

Once an emerging problem is identified, funding for different areas of research is largely determined by the state of the science. The next steps depend on the available insights and the extent of deficiencies in knowledge. The prospect that research will reduce the burden attributed to a specific disease is closely identified with the concept of scientific opportunity. Scientific opportunities can be identified and discussed, and their implications explored.

The distribution of NIH funding is influenced by the prospects for reducing the burden of a disease through research; by the relative promise of different fields of investigation, and by the complementary research activities conducted or supported by private enterprise and by other government agencies.

7.
Question:
Health Resources and Services Administration (HRSA) Mixed feelings about the HRSA budget...we have additions for nurse education – something that is important in my state which has one of the lowest nurse staffing ratios – health centers and HIV, but other programs such as Title VII health professions funding is zeroed out. Children's graduate medical education funding is severely reduced. The Administration has evidently explained some of these reductions are necessary because programs are poor performing and others did not have results which could be measured.

Let's be sure we don't have programs which are not effective, but for problems which did not produce measurable results, it is appropriate to terminate those programs because HHS perhaps does not have the right measurement tools in place?

Answer:
Decisions to reduce program funding are not made solely on the basis of any one performance tool, such as a PART evaluation. In the case of Health Professions, the priority is on distribution, and not volume. There is no longer a supply problem for physicians. HHS and HRSA prioritize the distribution of health professionals by maintaining funding for the Nation Health Services Corps ($126 million), which places physicians in underserved areas. In terms of the PART evaluation, several factors contributed to the PART rating of the Health Professions programs as ineffective. The PART assessment found that there is no clear and focused purpose for the programs, that the program has not regularly used performance data to improve outcomes, and that outcome data available from other sources on some programs indicate that the impact of the program may be limited.

While performance measures have aided budget decision making, in FY 2007, the Administration has proposed to reform the Children's Hospital Graduate Medical Education (GME) program. Payments will be made to hospitals with the greatest financial need; that treat the largest number of uninsured patients; and train the greatest number of physicians. With funding targeted to high need hospitals, less funding will be needed. Currently, the GME program provides payments to freestanding children's hospital to subsidize training costs without regard to financial need.

Senator Thomas

1.
Question:
Secretary Leavitt, during your confirmation process, you told me that rural health care issues would be a top priority at the Department of Health and Human Services.

As you know, I worked hard – along side many of my Finance Committee colleagues – to include a $25 billion rural equity package in the Medicare bill. While this measure went a long way toward narrowing the gap in Medicare payment inequities between rural and urban providers, it was not intended to be the

sole revenue source to shore up our nation's fragile rural health care networks. The Medicare rural equity provisions do not address other significant issues facing rural communities such as:

- Rural patients are diagnosed with more chronic conditions (i.e., diabetes, heart disease) and are less likely to have prescription drug coverage

- Rural areas have proportionately higher rates of uninsured and underinsured (fewer jobs offer employer-based health insurance)

That is why I was disappointed to see significant cuts to the Health Resources and Services Administration (HRSA) budget – eliminating or drastically reducing funding for critical rural programs such as the Rural Hospital Flexibility (FLEX) Grant Program, the Small Hospital Improvement Program, the Rural Health Care Services Outreach and Network Development Grant Programs, and the Rural Access to Emergency Devices Grants. These initiatives have proven themselves to be effective and efficient programs yielding results in my state.

If, as you contend, these rural health programs are not working and need to be cut, then please tell me what recommendations and strategic plans you are working on to fill the void eliminating these programs will create in rural and frontier areas?

Answer:
Rural health activities, within the Office of Rural Health Policy (ORHP), encompass several distinct programmatic activities, including Rural Health Policy Development, Rural Health Care Services Outreach Grants, Rural and Community Access to Emergency Devices, Rural Hospital Flexibility Grants, State Offices of Rural Health, and the Denali Commission projects. These programs are duplicative and redundant of other programs in the Department of Health and Human Services. The Rural Health Task Force identified more than 225 health and social services programs that address rural needs. The most notable is Community Health Centers. The President continued to carry out his initiative for health center expansion by requesting an additional $180 million for health centers in FY2007. Many of these new or expanded health centers will be located in rural areas and high poverty counties.

Senator Crapo

1.
Question:
As you know, I am the Chairman of the COPD Caucus and part of our mission is to demonstrate to CMS and the medical community at large the true value homecare provides in reducing expenditures and more effectively treating patients.

As you also may know, an entire year's worth of oxygen at home could cost less than a single day in the hospital. In order to keep homecare patients out of hospitals, we need to make sure that any changes to the homecare payment system does not harm continuity of patient care.

Mr. Secretary, before implementing any more changes to the oxygen payment system, will you consider conducting a full review of the entire range of services provided, incorporating input from the homecare industry, pulmonary physician groups, the FDA and other government agencies involved in the oversight of oxygen provided at home?

Answer:
The goal of the President's budget proposal is to make accurate Medicare payments in the program. Beneficiaries will save money with the President's budget proposal on oxygen equipment. This does not change the relationship between the beneficiary and the home oxygen supplier. After the beneficiary owns the equipment, he or she can still call the supplier when repairs, servicing and maintenance just like when the beneficiary was renting the equipment.

CMS would like to engage the home oxygen industry, pulmonary physician groups and others in discussions of the specific items and services that are needed by beneficiaries who use oxygen equipment and whether Medicare has a benefit category for such items and services, and how Medicare can assure that needed services are consistently provided. We encourage the home oxygen industry, pulmonary physician groups and others to meet with us to discuss these issues.

2.
Question:
Value-based purchasing is intended to help improve the quality of care for Medicare beneficiaries, but some of the legislation being considered for this also includes a concept called 'resource utilization.' I am concerned that if not written carefully, we will be penalizing physicians for providing the cheapest care instead of the best care.

Mr. Secretary, do you think that physicians should be rewarded for simply providing less expensive care without demonstrating that that they are also providing quality care? Could you suggest legislative language to Congress that would ensure any efficiency measures created by CMS would not compromise quality of care?

Answer:
The current physician payment system focuses on payment for individual services, but does not provide incentives for physicians to take into account all of the services furnished to beneficiaries to treat an episode of care, or furnished during a period of time to treat chronic disease. This often has the effect of directing more resources to delivering care that is not of the highest quality (for example, duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications). Conversely, providers who have good ideas and want to take action to improve quality of care find that Medicare's physician payment system does not provide them with the resources or the flexibility needed to do so. As a result, providers are unable to invest in activities that, properly implemented, have the potential to improve quality and avoid unnecessary medical costs.

Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that result in improvements in the value of care that our beneficiaries receive. CMS supports provider payment reforms that would encourage quality and efficiency, and discourage increased complications and costs.

A comprehensive view of performance has elements of both quality and resource use. Resource use measures need to be appropriately balanced with quality measures and adjusted for appropriate factors. A comprehensive view of performance involves multiple quality and resource use measures so that no single measure creates adverse incentives. "Pay for performance" is a mechanism to improve quality while avoiding unnecessary costs. We are working with our partners to understand not only how best to measure quality and resource use, but also how best to link the two for a comprehensive view of performance. We do not take the view that effective use of resources means less expensive care. We would be happy to work with you and your colleagues to design a system that links Medicare payments to valid measures of quality and effective use of resources.

Senator Rockefeller

1.
Question:
MEDICARE DRUG BENEFIT One of the things I remain concerned about is reimbursement to individual beneficiaries who have been overcharged for their prescription drugs. Many beneficiaries who are eligible for extra financial help have been inappropriately forced to pay the $250 deductible, premiums, and co-payments. However, HHS has only mentioned reimbursing states.

Last Wednesday, I received a call from the daughter of a Medicare beneficiary in Marion County. Her mother, who is a dual eligible, was enrolled in a Humana plan on January 9 and received her drug card on January 14. However, when the daughter took her to the CVS Pharmacy in Marion Square on February 1, they were told her three prescriptions would cost over $150.00 and that she had a $250 deductible.

Mr. Secretary, can you tell me what procedures HHS has in place to reimburse beneficiaries for these overpayments? Are you evaluating plan claims on a regular basis to check for payment errors?

Answer:
Part D plans must reimburse enrollees for costs incorrectly incurred. If a beneficiary is overcharged a deductible or copayment amount, they should contact their plan to find out how to submit a claim for reimbursement of the amount the plan should have paid and the cost sharing they should have paid. The person will need to save the original receipt from the purchase in case they need to submit it with the claim. Beneficiaries may also be able to contact their pharmacist to obtain receipts if necessary. The Medicare drug plan will refund the amount due.

2.
Question:
The claims review process will be critical to checking for beneficiary overpayments. Many duals will not know that they have been overcharged or how to go about getting reimbursed, so HHS should conduct active oversight of claims submitted by plans. The burden should not be on individual beneficiaries to come forward.

However, for those beneficiaries that do come forward, there should be a process in place to address their claims as well. Would it be possible for HHS to develop an education campaign that includes information on the Medicare website as well as outreach to State Health Insurance Assistance Programs (SHIPs) and community organizations regarding how beneficiaries who have been overcharged can get their money back?

Answer:
The Center for Medicare & Medicaid Services (CMS) has a number of education and outreach initiatives planned to ensure that beneficiaries who have overpaid for their prescription drugs under Medicare prescription drug coverage are reimbursed for any expenses charged in error. Outreach activities target not only beneficiaries, but also SHIPs counselors, pharmacists, community partners, and other information intermediaries beneficiaries are likely to turn to for help on this issue.

Communication Goals and Objectives:
CMS outreach activities will be designed to ensure the following:

- **Beneficiaries and caregivers** are aware that there is a process in place to get reimbursed for expenses charged in error, and have the information they need to navigate this process successfully
- **SHIPs counselors, pharmacists, community partners and other information intermediaries** understand the issues facing beneficiaries who have been overcharged, and are prepared to direct them to the appropriate resources

Communication Channels and Activities
CMS has planned a multi-channel approach to disseminate information on the reimbursement process to beneficiaries and information intermediaries. Activities include the following:

- CMS plans to develop and disseminate a beneficiary Fact Sheet on how to get reimbursed that walks beneficiaries through the reimbursement process step-by-step
- CMS plans to create 1-800-MEDICARE scripts for CSRs to help beneficiaries who have been overcharged navigate the reimbursement process
- CMS plans to incorporate appropriate beneficiary messaging into the Medicare Prescription Drug Plan Finder web tool and for posting on www.Medicare.gov

- CMS plans to translate all relevant beneficiary materials on this issue for the Spanish-speaking population
- CMS plans to ensure that pharmacies are aware of the reimbursement process and prepared to direct beneficiaries to appropriate resources at the point of sale
- CMS plans to develop appropriate pharmacist scripts on this issue for the1-866-MEDICARE pharmacy line
- CMS plans to develop partner messages on the reimbursement process for posting on the HHS and CMS partner websites
- CMS plans to develop and disseminate a Partner Tip Sheet to help advocacy groups, SHIPs, community partners, providers and other information intermediaries understand the reimbursement process and prepare them to counsel beneficiaries on this issue
- CMS plans to incorporate information on the reimbursement process into all related partner training materials
- CMS plans to put this item on the agenda for discussion at all relevant ongoing and ad hoc conference calls and meetings, including the SHIPS MMA Forum; all RO outreach calls; all Campaign-within-Campaign team calls; the various open-door forums for employers, providers, pharmacists, and others; and all other ad hoc conferences, teleconferences and meetings with relevant partners.
- CMS plans to develop an article on this issue geared towards providers for inclusion in the next edition of *Medicare Matters*

3.
Question:
Mr. Secretary, over the last several days, I have been reading in the news about several states that are receiving a reduction in the amount they are expected to pay the federal government this year for the Medicare prescription drug benefit. Can you please tell me what these reductions are based on and whether every state, including small states like West Virginia, can expect a reduction in their payments this year?

Answer:
The phased-down state contribution or "clawback" is a monthly payment for states. The clawback calculation reflects a portion of state savings due to the transfer of full-benefit dual eligibles from Medicaid to Medicare Part D. During the first year of the program, states will pay 90% of the estimated savings. Each subsequent year this percentage will decrease until it reaches 75% in 2014.

The recent change in the clawback estimation can be primarily attributed to the adjustment of two figures used in the clawback calculation. The first is the enrollment number for full-benefit dual eligibles. The second is the updated National Health Expenditure (NHE) growth estimate.

Instead of previously estimated dual eligible enrollment numbers, the new clawback calculation uses actual monthly enrollment numbers submitted by states. These updated numbers were favorable to the states and are more representative of actual experience than the anecdotal growth rates that had been provided by some states and used in earlier projections.

The updated NHE played a large part in the clawback recalculation. The changes in the updated NHE can be attributed to a variety of factors. The latest NHE estimates for prescription drugs show a per capita spending increase of about 7 percent from 2003 to 2004. Our previously estimated increase was about 11 percent. A main driver of this lower growth rate was a substantial deceleration in the price increase for generic drugs. The price growth of generic drugs fell from 13 percent in 2003 to only 3 percent in 2004. In addition, health plans successfully increased the overall use of generic drugs in 2004, and certain drugs went over-the-counter. There was also an increase in mail-order purchases. Finally, there was a reduced consumption of certain drugs due to safety concerns. When all factors are taken into account, the projected 10-year (2006-2015) state payments are 27 percent lower than the previous estimate. All states benefit from these changes.

4.
Question:
State Health Insurance Assistance Programs, or SHIPs, are overburdened and understaffed as they continue to take on more and more responsibilities under the Medicare drug benefit without adequate financial resources.

My state is no different. In order to meet the demands of the drug benefit, our state SHIP started the West Virginia Call Center on November 14. The call center has four staff members who are available 8 hours a day/5 days per week to address beneficiary concerns. However, because of scarce SHIP funding by the federal government, West Virginia SHIP had to raise $50,000 in private donations to start this call center and the funding is running out. Once this funding is gone, West Virginia will no longer be able to provide staff to continue the outstanding personalized assistance provided by this call center.

Mr. Secretary, when I looked through the HHS budget for fiscal year 2007, I could not find funding for state SHIPs. Now, this could be because SHIP funding is included in the administrative budget for CMS instead of as a line-item in the budget. However, I am hoping you can tell me how much in additional resources HHS is providing for SHIPs in fiscal year 2007.

Answer:

We are aware that SHIPs have experienced an increased demand for services with the start up of this important new drug benefit. As a result, we have placed heavy emphasis on building a more extensive network of partners to assist these programs in their education effort. The CMS Regional Offices have worked extensively to cultivate relationships with community-based organizations providing awareness, information, and enrollment assistance support at the community level. Furthermore, through joint effort of CMS and the Administration on Aging (AoA), the Aging Network has enlisted the active support of 10,000 aging services community provider organizations in beneficiary education and enrollment activities.

Each year, the Administration requests funding for the State Health Insurance Assistance Programs (SHIPs) within the National Medicare & You Education Program (NMEP.) This program is part of CMS' Program Management account which is funded through the annual appropriation process. The SHIP funding is part of CMS' community-based outreach efforts. In CMS' FY 2007 budget request, the Administration included $43.6 million for all of the community-based outreach. In FY 2007, CMS will continue to build on its grant relationship with the SHIPs, which are located in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. SHIPs provide one-on-one counseling to beneficiaries on complex Medicare-related topics, including enrollment in the new Medicare prescription drug benefit, entitlement, health plan options, Medigap, long-term care insurance, and Medicaid.

5.
Question:
MEDICAID AND CHIP As you note in your budget, and much to my dismay, the 2006 budget reconciliation bill has given states substantial new flexibility regarding Medicaid cost-sharing and benefits. In fact, many states will no longer have to pursue comprehensive Medicaid waivers because of the broad authority states have been given to change Medicaid eligibility rules and benefit design.

Despite the broad authority just given to states for this federal program, your budget states that you will be implementing a new waiver initiative that allows states to go beyond the authority in the new law. Can you tell this Committee more about this initiative and why you think it is appropriate or necessary to go beyond the bounds of what Congress has just enacted?

Answer:
The purpose of our waiver proposal is to expand health insurance coverage. While the Deficit Reduction Act of 2005 (DRA) provided a new option to expand coverage for children with disabilities as well as a demonstration to assist those in institutions transition to community-based care, it did not create new opportunities for states to address the issue of the uninsured.

Building on the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative and approaches adopted by innovative states such as Florida and Arkansas, the Administration will develop a new waiver initiative that emphasizes market-driven approaches to health care. In conjunction with the Deficit Reduction Act of 2005 (DRA), this approach allows states to emphasize expanding needed coverage to uninsured individuals and to promote greater continuity of coverage. This new model will stress consumer-driven approaches to health care with access to affordable coverage while giving states more tools to offer better health coverage to some current beneficiaries, as well as to individuals who are currently uninsured. By broadening choices and encouraging competition in the private market, Medicaid can continue to modernize through state-level reforms. The result will be more seamless access to coverage for low-income families and children in Medicaid, as well as to other uninsured persons with limited incomes.

While further details of the new Federal waiver initiative are being developed, this new model for demonstration initiatives will build upon past CMS and state successes with initiatives that include public-private partnerships, consumer and market-driven health care, tax credits, high-risk pools and premium assistance. HIFA demonstrations, which began in the fall of 2001, have allowed states to provide health care to more beneficiaries with the same amount of funding by changing delivery systems, redirecting current health care dollars to provide expanded coverage, and working with employers to ensure that employer-sponsored insurance (ESI) options remain available, and are in fact expanded. As of November 2005, over 800,000 individuals are eligible to receive health insurance coverage through HIFA demonstrations. The Administration hopes to increase this number by providing even more options to states for demonstrations to offer better health coverage to current beneficiaries as well as to expand coverage to the uninsured.

CMS will be making sure it gives states the options and tools they need to stay on the forefront of twenty-first century innovations in health care delivery and financing. Even since the recent implementation of the HIFA demonstrations, there have been additional innovations in the health care market through increased consumer information and decision-making, emphasis on personal responsibility and health care efficacy, and chronic care management coupled with technology. These developments allow new options that can benefit Medicaid and SCHIP enrollees. Consumer-driven options, along with other integrated market driven efforts, create opportunities for states to leverage this new flexibility to realign and reorganize their resources and funding streams to promote private market health coverage solutions through public/private partnerships and other approaches. Specific strategies could include ESI subsides in lieu of enrollment in Medicaid/SCHIP, Health Savings Account (HSA) and other incentive-based program features, Deficit Reduction Act (DRA) benefit flexibility, tax credits, transformation of categorical eligibility to income-based, and the collective power of coalescing divergent funding to encompass a greater share of low income working individuals and families.

Through approaches like these we propose to limit unsustainable increases in our health care spending through initiatives that will inject consumer involvement back into the health care system.

6.
Question:
There are several proposals in the President's budget that have moved from the "legislative proposals" section of the budget to "administrative proposals" section of the budget since last year. These proposals include:

- Phasing down the Medicaid provider tax from six percent to three percent;
- Capping provider reimbursement; and
- Reducing the availability of state Children's Health Insurance Program (CHIP) allotments from three years to two years.

As far as I'm aware, Congress has not given HHS additional authority in any of these areas since this time last year. So, I'm hoping you can tell the Members of this Committee what recently enacted statute or regulation you think gives HHS the authority to make these changes.

I would like to request that, by December 31, 2006, HHS submit to this Committee an objective and comprehensive state-by-state analysis of 1) the Medicaid changes states have made since enactment of the

fiscal year 2006 budget reconciliation law and 2) the people who have either gained or lost access to Medicaid benefits as a result of these changes. Is this something you think you can provide to the Committee by the end of this calendar year?

Answer:
The President's FY 2007 Budget proposes to revise the definition of an indirect hold harmless so that it would be considered to exist if the health care-related tax revenue collected by a state or unit of local government exceeds 3 percent (rather than the current 6 percent) of the taxpayers' net operating revenue applicable to the health care service assessed by the state or unit of local government. Section 1903(w)(4) of the Social Security Act establishes the direct and indirect hold harmless violations, which were implemented in Federal Regulations at 42 CFR 433.68(f). Section 42 CFR 433.68(f)(1)(i) implemented the statutory "indirect" hold harmless provision through a percentage limit on the collection of health care-related taxes. CMS will use its administrative authority through the regulatory process to revise the indirect hold harmless provisions contained in regulation to reduce the regulatory defined percentage from 6 percent to 3 percent.

The President's FY 2007 Budget proposes to protect the integrity of the Medicaid matching rate system by capping payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries, a step recommended by the General Accountability Office (GAO) dating back several years.

Section 1902(a)(30)(A) of the Social Security Act (the Act), which requires that payments be "consistent with efficiency, economy and quality of care," requires the Secretary to protect against abuses by states and providers. We do not believe that the taxpayer should pay more to a public entity than it costs to deliver the service to a Medicaid beneficiary. Additional authority to protect the fiscal integrity of the program is also found at sections 1903(i)(3) and 1903(i)(17) of the Act.

The President has proposed legislation to better target SCHIP funds to be used in a more timely manner to address potential FY 2007 state shortfalls by reducing annual SCHIP allotments from 3 years to 2 years. This is not an administrative proposal and remains a legislative proposal, as in the FY 2006 Budget.

7.
Question:
I would like to request that, by December 31, 2006, HHS submit to this Committee an objective and comprehensive state-by-state analysis of 1) the Medicaid changes states have made since enactment of the fiscal year 2006 budget reconciliation law and 2) the people who have either gained or lost access to Medicaid benefits as a result of these changes. Is this something you think you can provide to the Committee by the end of this calendar year?

Answer:

I am very hopeful CMS will be able to report on state activities and what states themselves report as to the impact and changes made as a result of implementation of the Deficit Reduction Act of 2005. It is not sensible, however, to separately analyze the impact of the DRA, especially since changes themselves may interact with other economic as well as programmatic changes. We can report data on overall expenditure and enrollment, but Congress has never given us the resources it would take to conduct independent analysis on a state-by-state basis.

Senator Bingaman

1.
Question:
Proposed Medicaid Cuts: Mr. Secretary, I see the budget proposes as additional round of Medicaid cuts in the budget bill. According to the Congressional Budget Office, the budget bill that the President signed last week will increase the number of uninsured people in the country, with over half of that increase falling on

our nation's poorest children. Those proposals only passed the Senate on a tie-breaking vote by the Vice President and by just two votes in the House.

What is disturbing about this year's budget is that, while you are seeking another $13.5 billion in cuts from Medicaid over the next 5 years, you are proposing to do so by making $12.2 billion of the cuts through regulatory measures. It appears that you recognize Congress is not interesting in cutting health care services further for the most vulnerable citizens in our nation, so you will largely go at it alone.

Ironically, virtually every single one of those regulatory proposals would directly cost shift on to state and local governments. I do not see how shifting $12 billion in additional costs upon the states is good public policy, but what is also troubling is that I do not see the legislative authority that CMS has to impose such burdens on the states and local governments, including public hospitals.

For example, what is the policy you are seeking to cut billions from public health care providers? Also, can you tell me under what regulatory authority you have that makes you think you can issue regulations that would cut $3.8 billion to public health care providers over the next five years?

Answer:
The President's FY 2007 Medicaid Budget proposals include both legislative and administrative proposals. Among these regulatory proposals, the Budget caps Medicaid payments to government providers. The Federal government should limit its contribution to the amount of providing its share of the cost of providing services to Medicaid beneficiaries. Other health insurance payers limit the payments made on behalf of their covered lives to the costs of providing care to those individuals. Medicaid should do the same. The General Accountability Office (GAO) has repeatedly recommended that payments to government providers should not exceed the cost of providing the services.

Through the Medicaid State Plan Amendment (SPA) reimbursement review process, CMS discovered that several states make claims for Federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the guise of intergovernmental transfers (IGTs) states and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state, which effectively shifts the cost of the Medicaid program to the federal taxpayer.

While CMS has been successful in terminating such practices, most government providers that were required to return payments through the IGT process, were returning the amount of the Medicaid payment in excess of cost. The Budget proposes to further improve the integrity of the Medicaid matching rate system by proposing steps to build on these past CMS efforts to curb financing abuses by capping payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries, a step recommended by GAO for several years.

Section 1902(a)(30)(A) of the Social Security Act (the Act), which requires that payments be "consistent with efficiency, economy and quality of care," requires the Secretary to protect against abuses by states and providers. We disagree that the taxpayer should pay more to a public entity than it costs to deliver the service to a Medicaid beneficiary. Additional authority to protect the fiscal integrity of the program is also found at sections 1903(i)(3) and 1903(i)(17) of the Act.

2.
Question:
Children's Health – Outreach and Enrollment: I very much support efforts such as that which you proposed on outreach and enrollment of children into health insurance coverage. As you know, I worked with Senator Frist and the Administration on the drafting and introduction of S. 1049, "Covering Kids Act of 2005," which has 6 Republican Senate cosponsors, 5 Democratic Senate cosponsors, and 1 Independent cosponsors. If there is truly one bipartisan approach to improving health care out there, this appears to be one place to start.

Can you give me the year-by-year projections you have on spending on outreach and the resulting costs in Medicaid due to increased coverage? How many children do you estimate will be covered by that initiative?

Answer:
The President's FY 2007 Budget outlines a legislative proposal entitled *Cover the Kids*. It proposes providing $100 million in grants and performance bonuses annually for FY 2007 to FY 2016 over ten years to enroll additional Medicaid- and SCHIP-eligible children by combining the resources of the Federal government, States, schools, and community organizations in a national outreach campaign. Many children are eligible for Medicaid and SCHIP, but are not currently enrolled. This program would give States the opportunity to work with schools and community organizations to enroll eligible children in either Medicaid or SCHIP so that they may obtain the healthcare coverage they are eligible to receive.

Table 1 outlines the projected fiscal impact of *Cover the Kids*.

	FY 2007	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Outreach	100	100	100	100	100	100	100	100	100	100
Medicaid	203	338	436	483	518	546	569	587	604	619
SCHIP	69	93	63	42	63	–122	–18	–18	–52	5
Total	372	531	599	625	681	524	651	669	652	724

Table 1. Year-by-year spending projections (in millions of dollars) during FY2007-2016 on outreach, Medicaid, and SCHIP as a result of the *Cover the Kids* proposal outlined in the President's FY 2007 Budget

Table 2 outlines the projected enrollment impact of *Cover the Kids*.

	2011 Projected Enrollment
Medicaid Children	240,000
SCHIP Children	30,000
Medicaid Adults	30,000
Total	300,000

Table 2. Projected peak enrollment numbers for people enrolled in Medicaid and SCHIP as a result of the *Cover the Kids* campaign.

3.
Question:
Child Care: The average annual cost of child care for a 4-year-old in this country ranges from $3,000 to over $9,000 a year. The cost is higher if the child is an infant, or if the parent actually wants to place her child in quality child care. Accredited child care can cost as much as $5,000 more a year than non-accredited care. Yet, according to the current services estimate in your budget, the number of children receiving child care based on the Administration's proposed funding levels will actually drop from 2.2 million children in 2005 to 1.8 million children in 2011. That's a loss of 400,000 children.

Can you explain how lower-income working families will actually be able to provide quality child care for their children under your budget?

Answer:
Providing access to quality child care does not necessarily mean center-based care is the best option for all families. Your question refers to an average annual cost of child care for a 4-year-old ranging from $3,000

to over $9,000 a year. This information was drawn from a recent report published by the National Association of Child Care Resource & Referral Agencies (NACCRRA), which based these estimates on the price of care in a licensed child care center.[1] Research shows that many families choose child care based on specific characteristics of that type of care, such as relationship with provider, convenience of location, extended family networks, and trust. These components of quality care can be found in family child care homes and informal care settings, such as with relatives, and in-home providers – not just centers. Parents may choose from a range of child care settings, and cost of care can vary substantially depending on these choices.

HHS data on child care funding in just three programs – CCDF, TANF, and SSBG – shows that funding increased more than threefold between 1996 and 2004, from approximately $3.6 billion to over $11 billion. In addition to these programs, it is important to understand that there are a number of other programs including Head Start, State funded Pre-K, and the 21st Century Community Learning Centers, that are providing quality care for children who otherwise might be in need of child care services during the hours they attend those programs.

On top of the significant increase in child care funding that already has occurred; the Deficit Reduction Act of 2005 provides a $200 million/year increase in child care entitlement funds through 2010. With the inclusion of State matching funds required to draw down these additional dollars, new funding for child care totals $1.8 billion over five years.

Your question refers to the projected beneficiaries table in the President's FY 2007 Budget, which does show a decline in the estimated number of children served. In our beneficiary projection model we first determine how much it costs to serve each child per year (adjusted for inflation) and then divide that amount into the total estimated funds available to serve children during the same year. This estimate assumes no State policy changes, yet in reality States have a great deal of latitude to set child care policies including income eligibility requirements and parent co-payments. States also may transfer up to 30% of their TANF funds to CCDF, or spend TANF directly on child care without limit.

According to a December 2005 survey of States by the National Governors Association and the National Association of State Budget Officers, State fiscal conditions rebounded notably in fiscal 2005 – revenues improved, balances returned to normal, and States were able to begin restoring funding to programs they were forced to cut during the economic downturn in 2001.[2] States contribute significant resources to child care, and have maintained high levels of spending during tough economic conditions. Better budget conditions can help States continue their strong commitment to early childhood care and education.

4.
Question:
Indian Health Service: IHS operates on just 57 percent of the budget it needed and had more than $3 billion in unmet needs in 2003. The United States Civil Rights Commission (USCCR) cites estimates by the Department of Health and Human Services (HHS) that per capita health spending for all Americans at $4,065, while IHS spent about $1,914 per person and average spending on Navajo patients is just $1,187.

The Civil Rights Commission points out, "In fact, the federal government spends nearly twice as much money for a federal prisoner's health care than it does for an American Indian or Alaska Native." Consequently and not surprising, this disparity in funding translates into severe health disparities for Native Americans. For example, life expectancy is six years less than the rest of the United States citizens. Tuberculosis rates are four times the national average. Complications due to diabetes are almost three times the national average and death rates exceed the Health People 2010 targets by 233 percent. Infant mortality rates are 1.7 times higher than the rate for white infants.

Last year, you may recall that I questioned you about the Administration's proposal to provide IHS will less than a 2% increase in funding. Although this year's proposal is a little better with a 3.2% increase, it is

[1] "Breaking the Piggy Bank: Parents and the High Price of Child Care," National Association of Resource & Referral Agencies, Appendix A, P.20 (February 2006).
[2] "The Fiscal Survey of States," National Governors Association, National Association of State Budget Officers (December 2005).

still well below medical inflation and population growth rates so funding for Indian health just continued to fall further and further behind. But, what is most disturbing in the budget is the proposed elimination of funding for urban Indian health centers.

In Albuquerque, New Mexico, there are over 30,000 Native Americans that are served at either the Albuquerque Indian Health Center or First Nations health center. Funding for the Albuquerque Indian Health Center has already dropped in recent years from $13 million to just $5 million. And now, the Administration is proposing to completely eliminate funding for the First Nations health center.

First Choice is the community health center clinic in Albuquerque and they have no ability to absorb the patient load and the $1 million lost if First Nations were to close. In fact, Albuquerque needs more health care services and clinics and not fewer.

Mr. Secretary, in light of the severe health disparities facing Native Americans across this country, I ask that you reconsider the proposed elimination of funding for urban Indian programs.

In addition, in FY 2006, the Indian Health Service received just a 1.7% increase over FY 2005 funding. This year the Administration's budget calls for just a 3.2% increase in funding (HHS Budget Document, page 24). Clearly, IHS funding continues to fall further and further behind the need. Just last week, a *Santa Fe New Mexican* article featured a story about the Indian Health Service being forced to deny treatment for a brain tumor due to lack of funding. This happens on a daily basis across this country and is a failure of the federal government to live up to its federal trust responsibility.

What is the long-term plan to get IHS funding back on track to meet the health care needs across this nation?

Answer:
As you know, budget requests for discretionary agencies like the Indian Health Service (IHS) are funded on an annual basis. The FY 2007 budget request clearly makes the IHS budget a priority for HHS. The four percent increase in budget authority requested for the IHS is higher than the rate of growth requested for any HHS discretionary agency and compares to an overall two percent decrease for HHS's total discretionary budget request.

Additional funding is targeted towards offsetting the increased cost of providing health care, continuing to serve a growing population of eligible Indian people, and expanding health care capacity in locations where it is most needed. In partnership with Tribes, IHS is transforming its health care system through its health promotion and disease prevention initiatives and the expanded use of health information technology.

5.
Question:
U.S.-Mexico Border Health Commission: How much funding does the Administration include in its budget for the U.S.-Mexico Border Health Commission?

Answer:
The President's fiscal year (FY) 2007 Budget includes $3,528,451 for the United States Mexico Border Health Commission (USMBHC). This represents an increase of $35,000 or one percent above the FY 2006 appropriated level.

6.
Question:
Diabetes Research and Prevention: Diabetes is one of the most prevalent, debilitating, and costly diseases facing our nation. The Centers for Disease Control and Prevention (CDC) estimates that over 20 million Americans live with diabetes at an annual cost well in excess of $100 billion. Furthermore, CDC estimates that one in three Americans will develop diabetes in their lifetime unless present trends are reversed.

In reviewing the proposed budget, there are cuts to diabetes research and prevention at the National Institutes of Health (NIH) and the CDC, respectively. This includes an $11 million cut in funding to the NIDDK and a $20 million cut to the CDC chronic disease prevention program.

A recent *New York* Times editorial ran on February 5, 2006, after a four-part series on diabetes and noted, "Waiting for this epidemic's fuller toll is foolhardy. Now is the time to develop a coordinated plan with a long view to take control of diabetes."

What is the Administration's plan to reverse the trend in diabetes confronting this nation?

Answer:
The Department of Health and Human Services (HHS) is aggressively spearheading efforts to combat diabetes, which places an enormous personal and economic toll on the U.S. For example, in December 2004, the Department released a "National Diabetes Action Plan" to mobilize Americans to take specific action steps to prevent, detect, and treat diabetes. The Department also leads the "Diabetes Detection Initiative," which is a campaign to identify the 6.2 million Americans who have undiagnosed diabetes and encourage them to seek treatment. Coordination of diabetes activities across the government is promoted through a statutory Diabetes Mellitus Interagency Coordinating Committee (DMICC), whose membership includes all NIH components involved in diabetes research, as well as other Federal agencies, such as the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), and the Veterans Health Administration (VHA).

Underlying the Department's efforts is the recognition that prevention is key to stemming the tide of diabetes – both primary prevention and prevention of life-threatening complications. NIH-supported research has identified effective prevention strategies at every stage of the disease. The Diabetes Prevention Program (DPP) clinical trial proved that people with pre-diabetes can prevent or delay development of type 2 diabetes by losing a modest amount of weight or by taking an insulin-sensitizing drug. The landmark Diabetes Control and Complications Trial (DCCT) demonstrated that type 1 diabetes patients can prevent or delay the development of complications by intensively controlling glucose levels. For patients who already have kidney disease, several clinical strategies have been identified that can significantly reduce their progression to irreversible kidney failure – known as end stage renal disease (ESRD) – for which dialysis or kidney transplantation are required. In this regard, data collected by CMS and analyzed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) supported U.S. Renal Data System now show that the incidence of ESRD is stabilizing after a 20-year climb, although minority groups still experience a disproportionate burden. These results likely flow from NIH research demonstrating the benefits of good glucose and blood pressure control, as well as research leading to the development of important kidney medications. In addition to the many accomplishments that have been realized through research, the NIH is setting the stage for developing new prevention strategies by identifying therapeutic targets and biomarkers needed to test new therapeutic agents.

To bring important findings to the public and health care providers, the NIH vigorously supports translational research efforts. For example, the NIDDK supports "Research Demonstration and Dissemination Projects" to translate advances in the prevention and treatment of diabetes into clinical practice for individuals and communities at risk. To translate the positive results of the DPP and encourage at-risk persons to make lifestyle changes proven to reduce risk of type 2 diabetes, the National Diabetes Education Program (NDEP) – a collaboration of the NIDDK, CDC, and over 200 public and private partners – developed the "Small Steps. Big Rewards. Prevent Type 2 Diabetes" education campaign. A key feature of this campaign is the design of separate, multicultural, science-based messages for minority populations who are disproportionately affected by diabetes. A parallel National Kidney Disease Education Program is raising awareness about the ominous link among diabetes, high blood pressure, and family history of kidney disease – particularly in African Americans. IHS efforts on prevention and control of diabetes are paying off with improved diabetes control in the American Indian populations they serve. Agencies within the Department have also collaborated to convene meetings of scientific experts to discuss translational research efforts. For example, the NIH and CDC brought together researchers, health care

providers, and payers to foster ideas to improve treatment for individuals with or at-risk for diabetes through implementation of proven prevention and treatment strategies. The FDA and NIH co-sponsored a meeting involving researchers and representatives from industry to discuss therapeutic gaps and hurdles to safe and effective prevention and treatment of diabetes.

Looking to the future, a strategic plan for type 1 diabetes research is now under development by the interagency coordinating committee I mentioned previously, with broad input from external scientific experts and patient representatives. Similarly, we will be guided by the many important research recommendations in an NIH strategic research plan to combat obesity – a frequent precursor of type 2 diabetes. To address the alarming trend of increasing rates of type 2 diabetes in youth, the NIDDK is supporting pilot studies in preparation for a larger study, expected to start in the fall, on a school-based effort to decrease or prevent the risk factors for type 2 diabetes. These are examples of the multifaceted research and educational efforts through which the Department is working to halt the diabetes epidemic in the U.S.

For over two decades, CDC's has based its national diabetes program on proven science for controlling diabetes and its deadly and disabling complications. We know that secondary prevention is a sound investment, and our programs are showing that with adequate time and resources improvements in preventive care practices are feasible and result in fewer amputations, blindness, and chronic kidney disease. CDC's program has four major program components:

- **National and State-based Diabetes Prevention and Control Programs:** The program provides funding for state-based diabetes prevention and control programs (DPCPS) in all 50 states and the District of Columbia. DPCPS are demonstrating improvements in eye care, foot care, influenza vaccines, and glucose control for people with diabetes.

- **Assessment of the Diabetes Burden:** States use CDC's Behavioral Risk Factor Surveillance System (BRFSS) to develop a nationwide, state-based diabetes surveillance system to define and track the diabetes burden.

- **Applied Translational Research:** The program conducts applied translational research that focuses on translating research findings into clinical and public health practice. For example, the CDC and NIH are funding SEARCH, a 5-year study, to examine the current status of diabetes among US children and adolescents. More than 5 million children 19 or younger are involved.

- **Communications:** CDC supports the NDEP multicultural diabetes prevention and control awareness campaigns are designed to improve treatment and outcomes for people with diabetes, and to promote early diagnosis of diabetes, and diabetes prevention strategies.

CDC will continue its efforts towards controlling diabetes and its complications and expand its program to include the primary prevention of diabetes. Based on the powerful evidence of several clinical trials, we now know that type 2 diabetes can be prevented and the risk for developing diabetes can be reduced by as much as 60% in people with pre-diabetes. CDC has initiated activities to help translate this new science into public health approaches to reach the 41 million at highest risk for type 2 diabetes – individuals with pre-diabetes. CDC's National Diabetes Prevention Strategy for preventing diabetes includes the following:

- Prevent diabetes in high risk persons (Pre-diabetes)
- Monitor national trends and identify persons with pre-diabetes
- Increase awareness and encourage broad-based public and private diabetes prevention strategies
- Create a network of organizations capable of delivering effective interventions in a variety of community settings
- Measure impact

7.
Question:
Obesity and Child Nutrition: In a related question, in American, we know the following:

– 1 in 7 young people are obese, and 1 in 3 are overweight;
– Obese children are twice as likely as non-obese children to become obese adults;
– Only 2 percent of children consume a diet that meets the 5 main recommendations for a healthy diet from the Food Guide Pyramid published by the Secretary of Agriculture; and,
– 3 out of 4 children in the United States consume more saturated fat than is recommended in the Dietary Guidelines for Americans published by the Secretary of Agriculture.

I know of your strong interest in prevention and desire to curb the growing obesity problem. Can you describe the Administration's agenda to combat obesity, including childhood obesity and nutrition?

Answer:
The Administration recognizes that combating the multi-dimensional, complex public health problem of obesity requires broad-based national efforts with contributions from numerous government agencies and others. Thus, vigorous, multi-pronged, and well-coordinated efforts on obesity are ongoing. In my 500-day plan with a 5,000-day horizon, I have included among the priorities: "Implementing a comprehensive plan for obesity research that will maximize collaboration among HHS stakeholders." HHS also works with other Federal agencies. For example, representatives from HHS, the Department of Agriculture, and the National Science Foundation shared information on their obesity-related efforts at a special meeting on obesity in September 2005, which was convened by the National Science and Technology Council Committee on Science. This meeting led to the formation of a new Interagency Working Group to further enhance coordination of obesity-related activities of the many Federal agencies that are addressing this problem within their missions and to engage the non-research agencies that may have programs that directly or indirectly impact development of obesity.

These activities support the President's *HealthierUS* initiative, which was launched in 2002 and designed to help Americans live longer, better, and healthier lives by eating healthier, being physically active, making healthy choices, and getting proper health screenings. On a policy level, the Department jointly developed and issued the 2005 *Dietary Guidelines for Americans* with the Department of Agriculture. These guidelines form the policy basis of all Federal nutrition education and promotion activities for healthy Americans aged two years and older. A major focus of the Dietary Guidelines is on maintaining healthy weight and preventing obesity through healthful food choices and physical activity, beginning with children.

Several major initiatives are underway within HHS agencies, including the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). CDC's State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases is designed to support states with developing and implementing science-based nutrition and physical activity interventions. In 2005–2006, 21 states are funded at $400,000 to $450,000 for capacity building. Seven states are funded at $750,000 to $1.3 million for basic implementation, bringing the total number of funded states to 28.

NIH, for example, recently developed and is implementing its *Strategic Plan for NIH Obesity Research.* NIH supports basic research on the biologic pathways underlying appetite, energy expenditure, and storage of energy as fat, and on the mechanisms by which obesity is associated with type 2 diabetes, cardiovascular disease, and other serious conditions. Its clinical research portfolio includes studies of behavioral and environmental approaches to achieve healthier lifestyles, of pharmacologic treatments, and of surgical interventions for extreme obesity. There is a diversity of racial/ethnic populations among the participants of these studies.

Childhood obesity is an important research focus. Recent NIH initiatives have led to new studies of approaches to prevention and management of pediatric obesity in primary care, school, and other settings. The ongoing Girls' Health Enrichment Multisite Studies is testing obesity prevention interventions for African American girls, who are at high risk of developing obesity. Another trial is testing a school- and

community-based program to prevent the decline in physical activity levels and cardiovascular fitness that often occurs as girls become young adults. Additionally, the NIH has developed plans for a study to start in the fall, called HEALTHY, that will investigate whether a school-based program including diet and physical activity components will help decrease risk factors for type 2 diabetes in middle school children. The NIH is also pursuing research on the influences of the built environment on obesity in children and adults. It also is translating results from earlier studies into programs that Americans can use to improve their health. "We Can! – Ways to Enhance Children's Activity and Nutrition," for example, is a national education program targeting youth ages 8-13 and their parents in home and community settings toward the goal of preventing overweight and obesity. Another campaign is disseminating results from the Diabetes Prevention Program (DPP) clinical trial, which was led by the NIH with participation from the CDC and the Indian Health Service. The DPP demonstrated that adults at high risk for type 2 diabetes can reduce their risk for disease onset through modest weight loss achieved by improved diet and moderate physical activity. Other areas of interest include the impact of diet composition on weight, bioengineering approaches to improve assessments of energy intake and expenditure, and factors during pregnancy (such as nutritional status of the mother) that may influence the offspring's risk of developing obesity and diabetes. The NIH also supports research on evaluation of obesity-related policies and the economics of diet, activity, and energy balance.

Agency for Healthcare Research and Quality activities include a healthcare cost and utilization project that has provided data on surgical procedures for obesity; systematic assessments of scientific evidence for prevention and treatment of obesity; examinations of approaches to decrease physical inactivity, improve diet, and encourage other healthful behaviors; and a survey used in examining associations between obesity and the use of medical services, expenditures, and health disparities.

The Department is developing brochures and toolkits to provide motivational information about healthy eating and physical activity for children and caregivers. Examples include the Office of Disease Prevention and Health Promotion's upcoming materials for parents and children of Head Start programs, the Office on Women's Health's new Body Works Toolkit for Obesity Prevention in Girls and their Families. The Department also is collaborating with several organizations to leverage their channels of outreach to children and adolescents to instill healthy eating and physical activity habits early in life. Examples include the Girl Scouts of the USA, the Boys and Girls Clubs of America, the Action for Healthy Kids coalition, American Medical Association, Strang Cancer Prevention Center, Shaping America's Youth, and Sesame Street Workshop.

Two major national conferences showcasing obesity prevention activities are planned for this year. On June 5-6, 2006, the Department will host a National Obesity Forum in Bethesda, Maryland. This meeting is a vital part of the Department of Health and Human Services' efforts to foster initiatives and collaborations at the community level that are consistent with *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, released in 2001. The meeting will serve to identify lessons learned in implementing change at the family and community levels from the ten regional conferences. Additionally, HHS' Fourth National Prevention Summit will take place October 25-26, 2006 in Washington, D.C. with a major focus on childhood overweight and obesity. The Prevention Summit brings together members of the health professions, public health community, federal, state and local governments, businesses and community-based organizations. The objective is to expand community outreach efforts and effective strategies for building private-public collaborations to support disease prevention and behavior change. HHS' annual Innovation in Prevention Awards will be presented to successful community prevention programs.

8.
Question:
Medical Research: In the late 1990s and the beginning of this decade, the federal government enacted a plan to double the nation's commitment to medical research in just five years. As a nation, we are making major advances to combat diseases and chronic illnesses, such as cancer, diabetes, Alzheimer's, and a whole range of other diseases.

Unfortunately, the NIH budget has increased at less than inflation for two years in a row and is flat funded, with actual cuts to the institutes, in the Administration's budget. This means a net loss of buying power and research grants in the coming year. According to Edward Miller and Martin Abeloff at Johns Hopkins, "On an inflation-adjusted basis, the current NIH appropriation is smaller than it was four years ago. In constant dollars, NIH funding has declined by more than $1 billion since 2003" (*Washington Post*, "Cancer Research in Danger," February 7, 2006).

How is the Administration's budget ensuring that progress in medical research continues to progress? What will happen to the pipeline of scientists and investigators working in biomedical research? And finally, how does the Administration ensure that the NIH Clinical Center is receiving the funding it needs under a flat budget when it must provide medical services and prescription drugs that are growing in the private sector at medical inflation rates well beyond that of general inflation rates?

Answer:
This budget request reflects the tough choices that had to be made during its formulation. To best preserve our investment in biomedical research and to support research for medical advancements that will improve the length and quality of human life, NIH has chosen to carefully invest in several trans-NIH strategic initiatives and priorities: support for new investigators, continued investment in the NIH Roadmap for Medical Research, a new initiative in Genes, Health and the Environment, and expansion of the Clinical and Translational Science Award program launched in FY 2006. NIH will continue to invest whatever funds Congress provides for the best science, and help speed the translation of scientific advances into therapies, cures, and diagnostics as quickly as resources will allow.

In the FY 2007 Request, NIH has identified $15 million for a new "Pathway to Independence" program that will provide increased support for new investigators and promote the initiation of independent research careers.

The FY 2007 request of $339 million for the Clinical Center represents an increase of 1.5 percent over the FY 2006 level, compared to the total NIH FY 2007 request which is the same as the FY 2006 level. Working through the NIH Management and Budget Working Group to develop the FY 2006 operating budget for the Clinical Center, NIH was able to successfully identify several areas of savings, without compromising the essential research support provided by the Clinical Center. NIH expects to continue these careful reviews as we move towards the implementation of the FY 2007 budget.

9.
Question:
Cancer Research and Prevention: The National Cancer Institute has established the goal of eliminating suffering and death from Cancer by 2015. In its budget request to the president, NCI indicated that the initial investment for achieving that goal would require a budget of nearly $6 billion for FY07. What can be done to get Cancer funding back on track?

I understand that there are 8 institutions currently preparing to apply for full Cancer Center Status. If the budget cuts enacted last year continue, how will those cuts affect the ability of NCI to designate new Cancer Centers?

The widespread use of breast and cervical cancer screenings could prevent nearly all deaths from cervical cancer and more than 30% of breast cancer deaths. However, the CDC's National Breast and Cervical Cancer Early Detection Program only reaches 20% of eligible women age 50-64 due to funding. We know this program reaches women who otherwise wouldn't be reached and saves lives, so how can we work together to ensure that the program has adequate funding to reach a greater percentage of eligible women?

Answer:
The funding proposed within the Administration's request provides nearly $4.8 billion for the NCI and represents over 16% of the funds proposed for the total NIH.

The Cancer Centers Program provides support for the entire spectrum of cancer research. It serves the majority of NCI peer-reviewed scientists with additional funding by providing infrastructure support for research from the lab to the clinic and for the conduct of early phase trials. Cancer centers also move research from the clinic into the community. Centers reduce direct costs to grantees, support technology and services and provide access to expertise for the education of new investigators. The proposed budget will severely reduce the ability of NCI to establish or expand the cancer center infrastructure including into underserved geographic areas of the US. NCI will also be unable to support new centers and will need to reduce the funding to existing centers below their recommended levels.

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) helps low-income, uninsured, and under-served women gain access to breast and cervical cancer screening programs in all 50 states, the District of Columbia, 4 U.S. territories, and 13 American Indian/Alaska Native tribes or tribal organizations. The Program has screened more than 2.5 million women; provided more than 5.8 million screening exams; and diagnosed 22,000 breast cancers; 76,000 pre-cancerous cervical lesions; and 1,500 invasive cervical cancers.

The success of the NBCCEDP has historically depended on the complimentary efforts of a variety of national, state, and local partners to help strengthen and maintain the program's infrastructure. In addition, CDC implements a variety of programmatic measures and processes to ensure that annual appropriations sustain program activities. For example, CDC awards performance based grants to ensure that all programs sustain and maintain capacity and capability to enroll new women, improve screening and re-screening rates, and reach women who have never or rarely been screened. Efforts also include the development and oversight of specific data collection indicators and demographic measures to ensure the delivery of timely and appropriate clinical services and that appropriate audiences are targeted for program activities.

However, current funding only allows the Program to reach or serve approximately 20 percent of the eligible population in this country. If additional funding becomes available, CDC would increase screening capacity to serve more eligible women, and ultimately save more lives. CDC's program could also continue to expand studies to monitor and further develop interventions to address breast and cervical cancer screening disparities between racial and ethnic groups. This would allow the program to better reach the rarely and never screened populations. For example, 60 percent of all cervical cancers are diagnosed in women who are considered to be never or rarely screened.

10.
Question:
Medicare Physician Payments: The Medicare physician payment issues and problems with the current formula continue to plague the program. What is the Administration's proposal with respect to correcting problems with the Sustainable Growth Rate (SGR) formula and the pending deep cuts in Medicare physician payments?

In addition, I recognize the Administration is proposing additional movement in Medicare to pay-for-performance (P4P) mechanisms. How would that work for physicians in light of the continuing problems with the underlying physician payment formula?

Answer:
The Deficit Reduction Act (DRA) of 2005 eliminated the negative physician update that would otherwise have taken place for 2006. In 2006, our efforts are focused on developing quality measures that would cover a broad group of physician specialties and a wide range of clinical areas for physicians to begin reporting in 2007. We are working closely with the physician community to develop these evidence-based quality measures for review by a consensus-building process. During 2006, we are conducting a physician voluntary reporting program to allow physicians to report some existing quality measures and to allow us to test administrative mechanisms for reporting such measures. We are also examining the administrative issues that would be involved with alternative mechanisms to reward physicians who report information on quality measures. As the year transpires, we will assess progress in the development of performance measures for physicians, as well as mechanisms for the reporting of measures in 2007. This will provide

physicians with the opportunity to report measures first, leading to payment for reporting and performance on such measures in the future.

The President's Budget indicates support for linking quality to Medicare payment in a cost neutral manner. Given concerns about the overall financing of the Medicare program, providing additional aggregate funding to finance incentive payments is neither supportable nor necessary. On the other hand, savings obtained from reducing care that is unnecessary or otherwise inappropriate affords opportunities to fund incentive payments. Payment reforms should consider the possibilities for improving care coordination and using some of the savings generated in one payment system to fund incentives in another, as long as these reforms do not provide inappropriate incentives to stint on necessary care.

The foundation of effective pay-for-performance initiatives is ensuring that valid quality and efficiency measures are used, that providers are not being pulled in conflicting directions, and that providers have support for achieving actual quality improvement. Consequently, to develop and implement these initiatives, we are collaborating with a wide range of health care providers, other public agencies, and private organizations who share our goal of improving quality and avoiding unnecessary health care costs. CMS is working with the provider community to identify and test budget-neutral incentives that will stimulate Medicare providers to improve performance on quality and efficiency measures.

11.
Question:
Funding for Medicare Counseling and Outreach: The complicated structure of the Medicare drug benefit necessities that Medicare beneficiaries by thoroughly educated and informed about the new program and the multiple choices available to them. However, groups providing personalized counseling, such as State Health Insurance Assistance Programs (SHIPs), have not been given sufficient resources. They have been understaffed and overwhelmed by calls. In a letter to the President dated December 15, 2005, Senator Max Baucus expressed concern that, of the $436 million it had for education and outreach, the Administration allocated just 7 percent to SHIPs.

What is the Administration's budget request for funding to SHIPs in FY 2007? Also, would the Administration support legislation or funding to the SHIPs to help them work through the complexity and issues created by the new Medicare drug benefit?

Answer:

We are aware that SHIPs have experienced an increased demand for services with the start up of this important new drug benefit. As a result, we have placed heavy emphasis on building a more extensive network of partners to assist these programs in their education effort. The CMS Regional Offices have worked extensively to cultivate relationships with community-based organizations providing awareness, information, and enrollment assistance support at the community level. Furthermore, through join effort of CMS and the Administration on Aging (AoA), the Aging Network has enlisted the active support of 10,000 aging services community provider organizations in beneficiary education and enrollment activities.

Each year, the Administration requests funding for the State Health Insurance Assistance Programs (SHIPs) within the National Medicare & You Education Program (NMEP.) This program is part of CMS' Program Management account which is funded through the annual appropriation process. The SHIP funding is part of CMS' community-based outreach efforts. In CMS' FY 2007 budget request, the Administration included $43.6 million for all of the community-based outreach. In FY 2007, CMS will continue to build on its grant relationship with the SHIPs, which are located in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. SHIPs provide one-on-one counseling to beneficiaries on complex Medicare-related topics, including enrollment in the new Medicare prescription drug benefit, entitlement, health plan options, Medigap, long-term care insurance, and Medicaid.

12.
Question:
Health Workforce Problems: For 25 years we have seen virtually no growth in the approximately 16,000 individuals graduating annually from the nation's allopathic medical schools. During the same period,

osteopathic medical schools have continued to grow and a variety of schools in another countries have been established that are largely devoted to the training of young Americans for re-entry into the U.S. workforce at the residency level.

Currently and for the past decade, 25% of the residency slots in the country have been filled by graduates of medical schools outside of the United States resulting in a physician workforce in the United States today that is roughly 25% foreign-trained. Even with this influx of foreign graduates into the U.S system there is a projected shortage of physicians. In addition to these issues, we continue to have substantial racial and ethnic disparities in our medical workforce that the current situation of limited opportunity only makes worse. Further, the heavy dependence of the United States on physicians and nursese from less developed countries such as India, the Philippines, and Nigeria harms the health systems of those countries.

In light of the health workforce cuts in the budget, I am interested in how you anticipate meeting the workforce shortages in medically underserved areas, including workforce for community health centers, and growing needs of the our nation's aging population and would you consider seeking an Institute of Medicine (IOM) study to help create a strategic framework to help address our nation's health workforce needs?

Answer:
As a result of evaluating the impact of HHS health manpower training programs in meeting the nation's top priorities—lessening the serious health disparities and the severe lack of health care services and personnel in our nation's most underserved areas—we have chosen to focus our resources on those programs which have the most successful track record in targeting those priorities and impacting those underserved communities. We therefore have increased the resources to expand our system of Community Health Centers, the facilities that provide services to our nation's most underserved populations. And we have increased our most effective program in recruiting and funneling health care personnel into the areas of greatest need—the National Health Service Corps (NHSC) Scholarship and increasingly the NHSC Loan Repayment Program. These facilities and these health care personnel serve all age groups in those populations most needing services, and focus on providing the services most needed in those communities and those that provide the widest impact.

The NHSC also has an outstanding record beyond the number of clinicians in NHSC services each year. In FY2003, 78.4 percent of the clinicians placed by the NHSC remain working in high-need areas after their NHSC service commitments have been completed, exceeding the performance target for the year. Thus funding NHSC manpower shows solid evidence of laying more permanent foundations of healthcare in our most underserved areas and building upon the infrastructure laid in previous years. The FY2007 Budget Request will fund about 120 additional Scholarships and Scholarship Continuations, and about 1,570 Loan Repayment, Loan Repayment Amendments or extensions, and State Loan Repayment awards.

In addition to our focusing resources on Community Health Centers and the National Health Service Corps, we have also responded to the nation's other most pressing health care manpower need, which in this instance clearly cuts across all boundaries—the increasing shortage of nurses nationwide. In addressing this problem, the Congress and the Administration have worked together to authorize new recruitment and training programs—most noticeably adding a Nursing Scholarship program to the Nursing Loan Education Repayment Program (NLERP) in the Nurse Reinvestment Act of 2002. Increases in funding for nurse training reflect this health manpower training priority. In FY1998, 170 Loan Repayment contracts were awarded. In FY2005, that number had grown to 650 new contracts and 250 contract amendments or extensions. One hundred percent of the program's FY2005 resources were awarded to nurses in critical shortage facilities. In FY2004 90 percent of former NELRP participants remained employed at a critical shortage facility for at least one year beyond the completion of their NELRP service. Thus our targeting of resources in this area also helps build up the infrastructure in shortage facilities beyond the immediate funding effects. In addition to the 744 Loan Repayment contracts supported in the FY2007 Budget Request, 225 Scholarships will also be funded, with a service commitment payback in a critical shortage facility.

Senator Lincoln

1.
Question:
Proposed Medicare Cuts:. Mr. Secretary, the President proposes in his budget to reduce the ambulance fee schedule by $10 million in 2007 and $290 million over five years. Many ambulance providers in Arkansas have closed over the past year, and those that remain have struggled to stay afloat. In fact, I just heard from an ambulance provider yesterday that CMS has frozen Medicare payments this week. These providers are the backbone of our communities, and many of my providers performed heroic work during the aftermath of Hurricane Katrina and Rita. What is your reason for cutting Medicare payments to ambulance providers? (This is not a MedPAC recommendation.)

Answer:
While ambulance services were not specifically addressed by MedPAC, this proposal is consistent with MedPAC's recommendation to reduce or eliminate updates for other Medicare providers. Under the President's budget, a range of providers would share equitably in modest reductions to support the program's future sustainability.

2.
Question:
Geriatric Health Professions Program: Mr. Secretary, for fiscal year 2006, Congress unfortunately eliminated a small but important program: the geriatrics health professions program. The Senate had funded the program in its version of the appropriations bill at $29.5 million while the House zeroed it out. This important program supports geriatrics training at all levels through support for geriatric education centers, fellowship programs, and small grants to junior faculty for career development. Since 2000, the Arkansas Geriatric Education Center has reached over 10,000 health professionals, most of whom practice in rural areas, and has provided over 54,000 hours of continuing education.

The elimination of this program runs counter to recommendations from the recent *White House Conference on Aging* where increased funding for geriatrics training ranked in the top ten list of recommendations. Furthermore, it ignores the well documented shortage of geriatricians and specialized care needs of the older portion of the Baby Boomer population. Because the program was eliminated last year, the President's FY 2007 budget does not acknowledge the program.

Mr. Secretary, will you work with Congress to restore funding for this vital program?

Answer:
I look forward to working with members of Congress to consider the issues of and potential solutions to address the concerns regarding the adequacy of the supply of physicians with geriatric training.

Overall, the number of physicians has been growing significantly over the past decade; salaries for primary care providers have also increased; and the physician population has increased at more than twice the rate of the total population. In the long run, the medical profession does react to the demands of the market place and I expect that it will do so again given the growth in the number of elderly. Responding to this demographic trend will be particularly important given the projected increase in the number of elderly persons with multiple chronic illnesses. As a result, geriatric training among medical professionals will be important.

The Geriatric Education and Training Programs secure support from a variety of funding sources – including Federal agencies such as the Department of Veterans Affairs and the Centers for Medicaid and Medicare Services. Other public and private policy solutions merit consideration when addressing the medical needs of the elderly.

One of the most vulnerable populations is the elderly in health professional shortage areas. Analyses found that eight of every 10 providers that benefited from Health Professions programs, such as the Geriatric Health Professions Program, did not practice in such shortage areas. The National Health Service Corps

(NHSC) has a successful record in getting and keeping health care personnel in these areas of greatest need. As we consider solutions for addressing the medical needs of the elderly, I believe that funds should be targeted to focus on the NHSC programs.

3.
Question:
White House Conference on Aging Mr. Secretary, what do you think of the recommendations made by the White House Conference on Aging in 2005?

Answer:
The Older Americans Act Amendments of 2000 provides that the final report of the White House Conference on Aging be transmitted to the President and the Congress not later than six months after adjournment. We look forward to the final report and the recommendations contained therein by mid-June.

4.
Question:
Social Services Block Grant Your budget proposes cuts to the Social Services Block Grant, reducing it by half a billion dollars. For Arkansas, that would be a cut of almost $5 million. SSBG is a critical source of funding for states and helps them fill in spaces where other funding does not go. In Arkansas, SSBG is used to provide transportation and home-delivered meals to seniors among other things. It's also important source of funding when it comes to services provided to disabled and at-risk children.

This cut to SSBG is worsening an already difficult situation. The recent budget reconciliation imposed new, and expensive, work rules on states through Temporary Assistance to Needy Families. The bill also freezes child care funding after 2006 and cuts funding to states through changes to child support enforcement.

At what point do all of the cuts to human services, such as child welfare services, reach beyond just "administrative" cuts and result in actual elimination of vital services to children and families?

Answer:
While the President's FY 2007 budget does propose a cut in funding for SSBG due to a lack of performance measures or other means to demonstrate that SSBG funds are producing results, there are other more targeted increases in the budget as well. For example, the President's FY 2007 budget, requests an additional $100 million for Family Formation and Healthy Marriage State grants, an additional $35.7 million for the Compassion Capital Fund, and $27.8 million for abstinence education.

Further, the Deficit Reduction Act (DRA) increased child care funding by $200 million a year, maintained TANF funding even though TANF caseloads are down by 57 percent (between August 1996 and June 2005), while providing an additional $150 million for Healthy Marriage and Responsible Fatherhood grants. The DRA also provided increased funds for court improvement and the Safe and Stable Families program. Also, while the DRA did include a reduction in Federal matching for certain child support enforcement expenditures, the law also made significant improvements in the amount of child support that can be directed to families.

5.
Question:
For years the Administration has touted state flexibility in many programs such as TANF, Medicaid, and SSBG. But given that the federal government has been gradually shifting costs to the state (for example: TANF child care, recent Medicaid changes, these SSBG cuts, among others), I'm wondering if the Administration's goal isn't state flexibility at all. And maybe, in fact, it's a move toward eliminating all federal financial support of these programs?

Answer:
The Administration remains committed to maximum state flexibility in administering block grant programs. However, our commitment to state flexibility operates in tandem with an expectation of good

performance. In keeping with this expectation, the President's FY 2007 budget focuses the limited resources available to programs that target a specific need and can demonstrate results.

With respect to SSBG, a review by the Office of Management and Budget (OMB) using their Performance Assessment Rating Tool (PART) rated the SSBG program as Results Not Demonstrated since it lacks a national system of performance measures against which outcomes can be determined and improvements sought. The funding reduction reflects the Administration's position that program performance outcomes may be achieved more effectively by careful targeting of federal dollars to other more clearly focused programs than through this block grant.

6.
Question:
Does CMS have any cost projections regarding how much both Medicare beneficiaries in particular and American taxpayers in general could save as a result of using more generic drugs?

Answer:

Increased use of generic medications will offer beneficiaries additional savings on their prescription drug bills, while also lowering the overall cost of the benefit and thus saving money for taxpayers as well.

For beneficiaries who take generic prescriptions, annual savings through PDPs can be as high as 72 percent – with similarly large savings available through the 10th-ranked and mid-priced plans (70 percent and 59 percent, respectively) – relative to what millions without drug coverage were paying prior to the drug benefit's implementation. In sum, by enrolling in any of a broad range of available Part D plans, beneficiaries can see savings that translate into hundreds if not thousands of dollars over the course of the year.

Generic medicines have the same safety and effects as brand-name drugs: they have exactly the same active ingredients, and they must meet the same quality standards as brand-name drugs. Most people with drug coverage today take generic drugs when they are available, and most prescriptions in the United States are for generic medicines.

Part D plans and the Medicare program itself are offering beneficiaries clear and comprehensive educational information and guidance about how to gain additional savings through the use of generic medicines.

Senator Schumer

1.
Question:
Medicaid School-Based Claims School districts are struggling with a lot these days. They're asked to meet greater accountability standards, but without the funding they need to meet those standards.

They're asked to provide first-rate education for disabled students, but not given the resources they need to do so.

But they can count on a little bit of help from the federal government. When schools provide health care services to special-needs children, they can get reimbursed by the federal government.

But this budget gives schools a double-whammy. First, it ends the practice of federal reimbursement for transportation and administrative expenses related to providing this care to special-needs students. In New York City alone, these transportation expenses add up to $15 million a year.

And second, it decreases the federal share of contributing to the overall education of these students. The federal government has promised to pay 40% of these costs. Last year it paid only 18%. And this year, the Administration's budget promises to pay only 17%.

And so, Mr. Secretary, I have two questions for you. First, what gives your department the authority to end the practice of reimbursing states and school districts for these transportation and administrative expenses without Congressional action? And second, what is your justification for making this change, especially in a year when the budget already proposes to decrease the federal commitment to special education funding?

Answer:
Claiming for Medicaid services in school settings has proven to be prone to abuse and overpayments. Problem areas include but are not limited to school bus transportation and administrative claiming, as well as direct medical services. The FY 2007 Budget proposes administrative actions to phase out Medicaid reimbursement for some services, including school bus transportation and administrative claiming related to Medicaid services provided in schools. Appropriate medical services, however, will continue to be reimbursed as under current law.

According to section 1903 (a) (7) of the Social Security Act, for the costs of any activities to be allowable and reimbursable under Medicaid, these activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid State Plan). Additional authority derives from section 1902(a)(17) of the Act, which requires that States take into consideration available resources. Through the authority of these statutes, the Administration proposes to prohibit federal reimbursement for transportation provided by or through schools to providers.

HHS has had long-standing concerns about improper billing by school districts for administrative costs and transportation services to and from schools. Both the Department's Inspector General and the General Accountability Office (GAO) have identified these categories of expenses as susceptible to fraud and abuse. GAO found weak and inconsistent controls over the review and approval of claims for school-based administrative activities that create an environment in which inappropriate claims generated excessive Medicaid reimbursements. Audit findings from states where the OIG conducted administrative claiming audits have shown egregious violations. Proper and accurate claiming for administrative services has not been carried out in compliance with applicable Medicaid regulations. Overall, the leading conclusions from these audits are that most states use an improper allocation methodology and insufficient attention is paid to the details of the claiming process.

The President's 2007 Budget includes a proposal that would prohibit Federal Medicaid reimbursement for Medicaid administrative activities performed in schools. It additionally provides that Federal Medicaid funds will no longer be available to pay for the transportation related to medical services provided through an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

Schools would continue to be reimbursed for direct Medicaid services identified in an IEP or IFSP provided to Medicaid eligible children, such as physical therapy and occupational therapy, that are important to meet the needs of Medicaid-eligible students with disabilities, as long as the providers meet Medicaid provider qualifications.

CMS estimates that these proposals will save $0.6 billion in FY 2007 and $3.6 over five years.

2.
Question:
Hospital cuts Secretary Leavitt, the Administration's budget includes $18.9 billion in cuts for health care providers under Medicare. Let me be explicit. This means $18.9 billion less money for hospitals, skilled nursing facilities, home health care, hospice.

Hospice. That's the service people can count on in their very darkest days, the service that allows them to live out the end of their lives at home. From this budget, New Yorkers can expect $18 million less support for hospice care.

And what about New York's hospitals? New York is a state with a vibrant hospital system, hospitals that train the nation's doctors and produce cutting-edge research, but that frequently run in the red.

You're proposing to cut $770 million from New York State hospitals that are already squeezed from both ends, expected to provide top-rate care and training while being shortchanged on the revenue side.

When you take all the provider cuts together to New York State, it adds up to $1.2 billion. Just for New York health care providers that are responsible for taking care of the sickest and weakest members of our society.

So Secretary Leavitt, I will simply ask you this. Why would your budget cut $19 billion for hospitals and other health providers when it spends $30 billion on expansion of health savings accounts, which will benefit those in the highest tax brackets?

Answer:
In order to ensure the strength and long-term sustainability of the Medicare program, it is important to regularly consider the need for payment updates as well as other payment policy changes. In keeping with the proposals for home health, skilled nursing facilities, and hospital payments, as you note, the President's Budget also includes proposals to reduce the amount of the annual payment updates to ambulance and hospice providers for years 2007-2009. This across the board approach for all providers builds on long-term Administration priorities for the Medicare program, such as improving quality and preventing medical errors, encouraging efficient and appropriate payment for services, fostering competition, and promoting beneficiary involvement in healthcare decisions.

Analysis of hospital payment adequacy conducted by the Medicare Payment Advisory Commission (MedPAC) indicates that there has been no significant change in hospitals' capacity to provide services to Medicare beneficiaries. Both inpatient and outpatient volume has increased, and spending on hospital construction has been growing. Although MedPAC reports that Medicare margins are decreasing, this can be attributed to unusually rapid cost growth due to unusual cost pressures, the lack of financial pressure to constrain costs, and the fact that hospitals with consistently high costs may not be efficient or competitive in their own markets. Consistent with MedPAC's recommendation and to ensure that Medicare payments reflect the costs of efficient providers, the Administration proposes to provide hospitals with a market basket update that encourages efficiency and productivity.

As you know, Health Savings Accounts (HSAs) have been available to the non-Medicare population since the President signed them into law in December 2003. They combine a high-deductible health plan with a tax advantaged personal savings account reserved for medical expenses. They give individuals greater ownership over their health care and can be a more economical choice than traditional insurance. Indeed, more than one million Americans have opted for an HSA since they became available in 2003. However, Medicare still does not offer any HSA options. The Administration is developing new Medicare HSA choices for beneficiaries to increase their options under Medicare and to make their choices more parallel to those available to the non-Medicare population. Among Medicare HSA options under consideration is an option allowing people to continue their existing HSAs when they become eligible for Medicare.

STATEMENT OF SENATOR GORDON H. SMITH

Finance Committee FY 2007 Budget Hearing
Secretary of HHS Mike Leavitt,
February 9, 2006

Mr. Chairman, thank you for hosting today's hearing to discuss the President's Budget for the Department of Health and Human Services. Our discussion will be valuable for all of us as we begin our work to develop the budget for fiscal year 2007.

Mr. Chairman, as you know last year the reconciliation bill passed by Congress included steep cuts that will harm Medicaid beneficiaries by increasing the costs they are required to bear and limiting their access to care. This year, the Administration is proposing an additional $12 Billion in Medicaid cuts. I am concerned that further cuts to Medicaid will result in poor and sick Americans losing their only safety net for critical medical services. As the number of Medicaid beneficiaries continues to rise, we must not shift costs onto the people who most need our help. Our government must have compassion for the less fortunate who are not able to make ends meet. We should continue to support vital safety-net programs that help millions of Americans keep their health, and their dignity, intact.

That being said, I am pleased there are a number of initiatives in the President's budget proposal that will help millions of Americans. One of these programs, Money Follows the Person, will make the Medicaid program more flexible. While most experts agree that the least restrictive setting is the most effective way to deliver assistance, the Medicaid program remains out-of-date because of its bias toward placing people in institutional settings. Last year, Congress passed Money Follows the Person legislation to help states remove this bias by allowing both federal and state Medicaid funding to "follow" people into the least restrictive, most appropriate setting. I am pleased to see that the budget continues to support this proposal by including funding for Money Follows the Person.

I also am pleased that the President has included a $70 million funding increase for the AIDS Drug Assistance Program. While this is a step in the right direction, there are additional concerns that need to be addressed. First, the new funding has been linked to helping states address problems with waiting lists. However, some states have avoided creating waiting lists by increasing cost-sharing or limiting the available drugs on their formularies. Oregon chose to pursue this route so that all those in need could receive at least some help with obtaining their medications. It is imperative that any new funding be distributed in such a way that it helps all states that are currently struggling to keep their ADAP programs whole, not just those with waiting lists.

I am also concerned that the proposed new funding will not go far enough to meet the demand that ADAP programs will face in the coming year. Conservative estimates place the funding needed to keep pace with caseload growth at around $84 million. Last year, I offered an amendment to the Labor HHS appropriations bill that would have increased funding to meet expected ADAP caseload growth, and I will continue that effort during this next budget cycle to

ensure that low-income individuals with HIV/AIDS have access to potentially life-saving prescription drugs.

I am also encouraged by the focus on mental illness in this budget. Mr. Chairman, as you are aware mental illness is a personal issue for me. With the strong support of the President I was able to see the Garrett Lee Smith Memorial Act signed into law in the fall of 2004. Despite this milestone, we have many challenges ahead, including securing full funding for the Act. This past year, with the support of my colleagues, I was able to secure $26.6 million for the Garrett Lee Smith Memorial Act. The President's FY07 Budget request funds the measure at the same figure: $26.6 million. Mr. Chairman, I will be working to secure full funding of $40 million and I would appreciate your support as we work through the appropriations process.

Finally, while I am pleased the President's budget includes funding to allow refugees and asylees to receive SSI benefits for an additional year, I think we can do better. I will be introducing legislation that will allow refugees and asylees who come to America to seek a better life to receive SSI for an additional two years. It is my hope that my colleagues will support a two year extension to allow adequate time for asylees and refugees to become naturalized citizens.

I want to thank Secretary Leavitt for appearing today to discuss some of the most important programs in the federal budget. I look forward to working with you to help ensure our government meets our obligation to those who most need our services.

Thank you Mr. Chairman.