S. HRG. 109–170

NOMINATION OF MICHAEL O. LEAVITT

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON THE

NOMINATION OF

MICHAEL O. LEAVITT, TO BE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 19, 2005

Printed for the use of the Committee on Finance

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CONTENTS

OPENING STATEMENTS

CONGRESSIONAL WITNESS

ADMINISTRATION NOMINEE

ALPHABETICAL LISTING AND APPENDIX MATERIAL

NOMINATION OF HON. MICHAEL O. LEAVITT, TO BE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

WEDNESDAY, JANUARY 19, 2005

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

The hearing was convened, pursuant to notice, at 2:08 p.m., in room SD–215, Dirksen Senate Office Building, Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Lott, Snowe, Kyl, Thomas, Smith, Bunning, Crapo, Baucus, Rockefeller, Conrad, Bingaman, Lincoln, and Wyden.

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

The CHAIRMAN. This is the first meeting of this committee in the new Congress, and we have three new members that we all know as members, but I think they ought to be mentioned to the public at large.

We have Senator Wyden, who is here right now as a new member. He is a Senator from Oregon. We have Senator Schumer, who cannot be here right now. It is my understanding that he cannot get down here right now because of travel from his home State. But Senator Schumer of New York is a new member. Then over here on this side, not present right now but I know he is in town today, is Senator Crapo from Idaho. So, we welcome these three members to the committee.

Also, obviously we want to welcome back the returning members of this committee because this is a committee that has had a great deal of collegiality and camaraderie, and a lot of progress that comes from that sort of environment.

But we do have very challenging work before us on some of the most important issues facing the country, and we look forward to working with all of the members of these committees to work on the agenda that is coming up shortly.

Second, our procedure today is that Senator Baucus and I are going to make opening statements. After opening statements, we will hear from Senator Hatch and Senator Bennett to introduce Governor Leavitt. Then Governor Leavitt will testify before our committee.

Following that, Senators will have 5 minutes each to ask questions. I am going to start, followed by Senator Baucus. Senator

Baucus will then be followed by the Senators in the order of their arrival, in addition to the people that are here, by seniority, getting recognized in that direction.

If things can be worked out, and we do not have a quorum right at this particular minute, and it would not matter if we did because I know we have got to go through it.

But at the end of this hearing, if we could do like some other committees have done—and we are only going to do this if we have the permission of Democratic members—I would like to take action on Governor Leavitt's nomination. So, keep that in mind. If some of you ask questions and leave, maybe you could come back and help us have a quorum for doing that.

Governor Leavitt, we welcome you. First, before we talk about the issues that come before you and this committee and my statement on those, I think we ought to thank Secretary Thompson, your predecessor, for devoted public service over the last 4 years in the position that you are being appointed to, as well as a lifetime of public service that he had in the State of Wisconsin.

During Secretary Thompson's tenure, he successfully led the Department through the September 11 tragedy, the flu vaccine shortage, and he also was very instrumental in the passage of the Medicare Modernization Act and has successfully completed 200 regulations on time, with 27 regulations pending publication. That is a difficult task to do in a short period of time, to get that new legislation ready for people's participation.

Looking back at these past events and looking forward to the new challenges that await us, it is most fitting that we start the first health care hearing of the 109th Congress with the nomination of you, Governor Leavitt.

During your term as governor, you have had an opportunity to reduce the number of uninsured children through your work on the Children's Health Insurance Program, and significantly increased the number of those with health insurance coverage, in my understanding, by more than 400,000.

You have improved immunization rates by at least 75 percent and made significant improvements to the child welfare system. I am certainly not alone in my high estimation of you as governor of your State. The people of Utah recognized this with three consecutive terms.

I have a longer statement that I will submit for the record, but right now I would like to concentrate on a couple of key issues.

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

The CHAIRMAN. Big challenges lie ahead for this Department and strong leadership is needed. First and foremost, is an estimated 45 million Americans lacking basic health coverage. Each year, the ranks of the uninsured increase.

As Secretary, your leadership will be called upon to propose innovative ways that we can help constrain costs and increase access to health care. This is surely one of the biggest health care challenges of our time.

The Medicaid program is the key Federal program for providing health care access to low-income individuals. It is now the largest

Federal health care program in terms of total spending and serves 51 million people.

Yet, it was originally enacted in 1965, and many have suggested that it has not kept up with today's challenges. I look forward to working with you as the new Secretary to ensure that Medicaid and the State Children's Health Insurance Program are functioning as effectively as they should.

Your Department also has the important job of implementing the new Medicare prescription drug program. Under Dr. McClellan's leadership, the Centers for Medicare and Medicaid Services has accomplished an impressive workload over the last year.

Dr. McClellan and his staff at CMS are to be commended for their long hours, hard work, and dedication. This is a crucial year for drug benefits, and I look forward to working with you as we further implement this program.

Medicare will still face significant challenges. Many have said rising Medicare costs can be contained and health care quality improved by paying providers based on their performance and by utilizing high information technologies.

Bringing these initiatives together to reward quality and efficiency, while reducing medical errors and duplication will be one of the major undertakings in health care over the next decade. Strong leadership at HHS, with the cooperation of this committee, is needed to help make that happen.

Another issue on which your leadership is needed is the importation of prescription drugs from Canada and other developed nations. We may even have some disagreement on it, but at least I think it is a very important issue. American consumers are demanding lower prices, and I believe that legalizing importation is one way to help do that, as long as we ensure safety.

Besides these issues, the Department faces other challenges. I have always taken the responsibility of conducting the oversight of the executive branch very seriously. I have, and will continue to do so, as Chairman of the Finance Committee. Government truly is the people's business, and the American people have a right to know, with more transparency in government.

In that regard, I am a firm and ardent supporter of most whistleblowers, most meaning those that are credible. Historically, whistle-blowers have been the key to uncovering waste, fraud and abuse. Unfortunately, whistle-blowers are often as welcome as a skunk at a picnic.

Particularly, the Food & Drug Administration has come under increasing scrutiny on issues of drug safety. Governor Leavitt, it will require your strong leadership to make the FDA more transparent and to restore the public trust.

Scientists working in that office are not to be muzzled and overcome by pressure placed on them by other offices at the FDA. The American people deserve to know that their drugs are safe. A number of individuals have blown the whistle at FDA. These patriotic Americans are scared that if they tell the truth, they will suffer retaliation at the hands of senior officials.

With that in mind, Governor Leavitt, I want your public assurance that anyone who exposes problems at your Department will have their rights as Federal employees fully respected and will be

permitted to speak with this committee, or any member of Congress, without fear of reprisal.

Do I have your commitment, Governor Leavitt? You understand that I need employees at the Department to hear you, because I know that they are listening.

Mr. LEAVITT. Senator, they will be treated with respect and dignity, and taken seriously.

The CHAIRMAN. Thank you. I look forward to addressing these problems with you. It is my hope that the Finance Committee will work closely with you to address some difficult issues affecting millions.

Taking a closer look at Medicaid and the CHIP programs and their improvement, implementing a new Medicare drug benefit, importation of prescription drugs, enactment of welfare reform, and the advancement of information technology and quality in health care are just some of the priorities I look forward to addressing with you, Governor Leavitt.

Let me close by thanking you for your willingness to serve as Secretary of Health and Human Services. It is a major commitment that requires personal sacrifice. I also thank President Bush for his choice of you as a qualified person.

I now have the opportunity to listen to Senator Baucus, then we will go to Senators Hatch and Bennett.

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

Senator BAUCUS. Thank you very, very much, Mr. Chairman. I think every member of this committee knows, and certainly the new members are going to find, that you are extremely fair, extremely gracious, and this is a committee where we work together.

I welcome the new members of the committee, most of whom are not here today. They are definitely going to find that the partnership that you and I have, Mr. Chairman, is pretty much shared by other members of the committee. We are very proud of that, that we work together to try to find solutions.

We are not idealogues, not partisan, but, again, we try to find solutions. Sometimes that means digging down a little more deeply. Sometimes it means asking a lot of questions. Sometimes it means looking at assumptions behind different proposals.

But it is our view, and I know you share this with me, Mr. Chairman, that it is why we are serving. It is the best service we can provide to the people we represent, for whom we work, that is, for our employers around the country.

I just want to tell you, as one member of the Senate, how much I appreciate the approach that you take, because a lot of things begin at the top. You are at the top, and your manner, your demeanor, your approach, your goodwill, and your faith all fall down a little bit, and this is one area where I think maybe trickle-down makes sense. So, thank you very much for what you do.

Second, I think there is a good chance that we can report out the nomination favorably—I hope so—today. As you know, Mr. Chairman, Governor/Administrator Leavitt and I have been discussing the last day, actually, several times, information that I have re-

quested, and the Department is working very hard to get that information to us.

We have a little bit further to go, but I think we are going to get there. I, again, thank you, Administrator Leavitt, for your hard work in helping to make that happen.

Mr. Chairman, we all, clearly, welcome Administrator Leavitt to this committee, to this hearing, and to his new job. It is not going to be an easy one, clearly, with such a huge, massive Department that Administrator/About-To-Be-Secretary Leavitt is going to oversee.

I think he has a lot of good experience in Utah as chief executive, with the innovative approaches he has taken to, particularly, Medicaid in Utah, which I think he is going to bring to the Department.

We thank you very much, Mr. Leavitt, for bringing that experience and that approach to your new position. You have a great reputation as a consensus builder, and this committee certainly appreciates that.

As you know, Mr. Leavitt, Medicare is one of the few responsibilities that you have, and it is huge. It covers over 40 million Americans and is at the heart of the compact that we, the government, have made with our elderly and disabled. Also, Medicaid, the health care safety net for nearly 50 million beneficiaries. And TANF, which helps the neediest families among us. Of course, that is not all.

HHS also administers day care, foster care, initiatives to reduce drug dependency, prevent child abuse and domestic violence, and, of course, the Indian Health Service, which, as you probably know, has awaited authorization since 2001.

But again, as Utah's longest-serving governor, you earned a reputation as an innovator and a consensus builder, traits that are sorely needed as we move forward on issues before this committee, and as a general tone in this town. I very much urge you to work at that very hard, because it is the right thing to do. And who knows? After a while, maybe it might be a little contagious. It might catch on a little bit.

Just a couple of words, starting with Medicare. I played a large role in the passage of the 2003 Medicare prescription drug bill. I might say, I await quite anxiously the Department's publication of the final rule to implement major components of that law, particularly in a couple of areas.

One is the transition from Medicaid drug coverage to Medicare for those who are eligible for both programs. Next, consumer protections to ensure access to necessary drugs. It is very important that strong consumer protection provisions are in place.

Rules for interactions between State pharmacy plans and Medicare. Many States have State pharmacy plans, which are extremely important, as you know. Other States do not, and that interaction is critical.

Rules for calculating payments to States, also known as clawbacks. As a governor, you surely know a little bit about that. Rules related to employer subsidies for retiree drug coverage, and rules covering access for drugs to Indian populations and nursing home residents, among others. We need to know those rules to give guidance to many stakeholders.

When we recently met, you drew a parallel between the implementation of the Medicare law and the stakes involved in staging a successful Winter Olympics in Utah. You said that implementation of the bill is the Olympics of this administration. I am glad you are taking that approach. I could not agree more.

The 2003 Medicare bill is the largest expansion of Medicare since its enactment in 1965, and proper implementation of the new law will, frankly, determine my level of continued support for it.

Medicaid. Medicaid now surpasses Medicare in the number of beneficiaries enrolled and in total spending. It has come under fire in recent years, especially from this administration, as being too costly, too tolerant of fraud, too inflexible.

It is true that Medicaid costs are growing, but that is mostly due to an increase in enrollment and the same health care cost inflation that affects every insurance plan. In fact, Medicaid growth is lower, on a per capita basis, than both Medicare and the private insurance sector.

We also hear that Medicaid is a Cadillac program compared to the private sector. Well, you have to keep in mind that, unlike most private insurance, Medicaid also covers long-term care.

On fraud and abuse, CMS said last week that, based on solid, reliable data, $119 million in Federal Medicaid spending was attributable to fraud in 2003. Let me just remind you, that is less than 7/100ths of a percent of total Medicaid spending. If I scored 99.93 on an exam, I would be pretty happy.

But, of course, the administration believes—and it is probably true—that other fraud and abuse exists. But identifying calculable fraud, so far, by CMS is limited to $119 million, a far cry from the $20 billion cut in Medicaid that the administration proposed in its 2005 budget last year.

If forced to make cuts in Medicaid this year, we should all realize that it is unrealistic and it is misleading to say that we are simply cutting fraud and closing loopholes.

With respect to Medicaid reforms, my views are similar to what yours were as governor. Namely, you opposed caps on Medicaid spending as governor of Utah. I, too, think we should not have caps on Medicaid spending.

Ironically, it is hard caps on Federal Medicaid spending that reduce flexibility, not increase it. This is flexibility that has allowed a swift response to recessions, to epidemics, to disasters like 9/11, and dramatic treatment innovations.

I also have concerns about the administration's use of the so-called 1115 waiver authority designed to allow States to experiment and to innovate in Medicaid programs.

I am all for innovation, and I am sympathetic to States' desire to experiment with novel approaches to cover the uninsured. But we must not undermine Medicaid in the process. I do not believe that the 1115 waiver authority allows wholesale reform of Medicaid. That is not what the law provides.

The non-partisan Government Accountability Office agrees. The GAO has identified key areas where this administration has overstepped its statutory bounds in granting waivers. So, I expect the administration to follow the law, and that has not been happening with respect to Medicaid waivers.

A couple of points on TANF, which Congress has tried to reauthorize for the past 3 years and which must be extended yet again before the end of March. I was an eager supporter of welfare reform. I remember sitting in this committee. Most of my colleagues thought I was nuts, but I thought it was the right thing to do. I am glad that we passed it. It has worked. We should authorize TANF as soon as possible.

In my view, that means continuing our investments to support working families through child care, through education, through training, through transitional health care. We have got to support working families. In Montana, TANF reauthorization also means continued access and flexibility for American Indian tribes.

In Montana, we had a successful Welfare-to-Work strategy, and we should recognize those successes in our country where they exist. In other words, TANF reauthorization should not be about fixing a program that ain't broke.

Finally, I hope we can do something, work together, in a realistic way, to address rising health care costs and the uninsured. The United States health care system is the most expensive in the world, by far. We learned last week that spending on health care in the United States reached $1.7 trillion in 2003, which comes out to $5,670 per person.

Yet, 45 million Americans lack health insurance. The next highest country, on a per capita basis, I believe, is Switzerland.

Our health care system affects the ability of U.S. companies to compete abroad. I remember talking to the CEO of General Motors not too long ago about how his biggest bill is his legacy costs, his health care costs. It is not steel, it is his health care costs, which makes it very difficult for American auto companies to compete worldwide.

In fact, I should note here that Medicaid enrollment increased by 7.5 million between 2001 and 2003, in part because of the downturn in the economy, and in part due to losses in employer-sponsored health coverage. If not for Medicaid, the uninsured rate would be even higher than it is today.

So what can we do about the uninsured and rising health care costs? On the uninsured, every major poll suggests that covering the uninsured should be at the top of the Congressional agenda. Yet, this issue always seems to take a back seat.

So what do we do about this? I think we should do our best to try to make some progress. Maybe not sweeping reform, but we can address the problem incrementally, starting with areas of general agreement.

I believe there is a consensus that we ought to start by covering low income children better, and the poorest adults, say, below 100 percent of poverty. I hope, Mr. Administrator, that you will keep working on this issue, and I pledge to work with you.

On health care costs—and I am about to finish here—we have to continue to improve health quality. Americans receive appropriate, high-quality health care services only about half the time.

An estimated 270 people die each day in America as a result of medical errors. These numbers should shock us into action. We can take important steps this year to improve health care quality. I hope we can count on the administration's support in that regard.

There are lots of good people working very hard at improving quality, measuring outcomes, finding ways to reduce infection rates in hospitals, which is a very, very costly part of health care, and an unnecessary part of health care today.

Before I close, I want to thank you very much, Mr. Administrator, for visiting Libby, Montana. I asked you to come to Libby a couple of times. You were very gracious and found a way to fit it into your schedule quite quickly.

As you well know, the people of Libby really need some help and they really appreciated your visit. That meant a lot to them, and your visit meant a lot to me. I hope, in your capacity as Secretary, you can come back to Montana fairly frequently.

Thank you for your service, again, not just as governor, not just as the Administrator of EPA, not just as a political leader, but as someone who is creative, works together, and thinks outside of the box. You are a great asset to this country and to the administration.

The CHAIRMAN. Thank you, Senator Baucus.

Now we go to Senator Hatch, and then Senator Bennett, for their introductory statements. Then we will go to Governor Leavitt.

Senator Hatch?

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

Senator HATCH. Thank you so much, Mr. Chairman. I personally want to express my gratitude and thanks to Secretary Thompson for the great work that he has done during the time that he has served at HHS. He is a fine man. I think if he were to choose a successor, he would have chosen Mike Leavitt. I am sure he had some input on it anyway. The fact of the matter is, he knows Mike, he knows what a great governor he was, and a great head of the Governors Association as well.

So, it is my honor and privilege to introduce, along with my friend and partner Senator Bennett, our good friend and fellow Utahn, Governor Michael Leavitt. I have known Mike Leavitt for a long time and have worked closely with him on many key issues, not only Utah health issues, but national health issues as well.

We are all aware of Mike's distinguished record. I do, however, want to convey to you how qualified Mike Leavitt is for this job. In short, he is bright, energetic, dedicated, and fair-minded, all of the qualities necessary for this important and difficult job. I say, with all respect to those who have gone before him, I can think of no better Secretary of Health and Human Services than this man. I think he will be a great one.

Mike has devoted much of his life to public service, first in Utah, and more recently here in Washington. He is a smart decision maker, a tireless worker, and a successful manager and executive. He is fair, he is knowledgeable about health care, he is a good and decent family man.

His wife Jackie is here today, and we are happy to see her here today. She was not feeling well yesterday. She is a wonderful woman who has done an awful lot herself in the State of Utah to help all of us feel better about ourselves and to do some of the things that should be done from a charitable standpoint. He and

his wife have wonderful children, five of them, that I think any of us would be proud to associate with.

I might add that Jackie Leavitt was born and raised in a little town called Newton, Utah. There used to be about 300 people, and there are 500 now. That is where my wife was born and raised as well. So, we are proud of saying that Newton, Utah is one of the most well-represented cities in America. At least, we think so.

As governor of Utah, Mike Leavitt was a leader on issues with which this committee is very familiar, important issues such as welfare reform, health care delivery, and Medicaid. During a difficult financial time for our State, he was able to create a fiscally responsible budget, and at the same time provide important services to lower income Utah citizens of all ages.

While we were, in this committee, working on the CHIP legislation in 1997, I talked with Governor Leavitt frequently to get his perspective as a leader in the National Governors Association. He provided me with valuable insight and has continued to do so as the program has grown.

I would be remiss if I did not cite Governor Leavitt's work in providing health care coverage not only to CHIP-eligible children, but to lower income adults within our State as well through innovative State health care insurance programs like the Primary Care Network.

On a personal note, I want the members of our committee to know that Mike Leavitt is a fair man. He will look at all sides of an issue before making a policy decision, and you can count on the result to be the right result and the right decision. His record as both the governor of Utah and the Administrator of EPA proves this, and he will continue to be a great leader when he becomes Secretary of HHS.

I can promise you that he will become an excellent leader for the programs we work on daily: Medicaid, CHIP, welfare, and FQHC, just to name a few. Importantly, we can count on Mike Leavitt, along with CMS Administrator Mark McClellan, to work closely with the committee on the difficult task of fully implementing the Medicare prescription drug program next January.

Although FDA is not within this committee's jurisdiction, I just wanted to close with one anecdote that a senior official at FDA related to me the other day. After attending several briefings with the Secretary-designate, the FDA official said, "At our first briefing, Governor Leavitt was good. At the second meeting, he was excellent. At the last briefing, he was teaching us."

I think that sums it up. That is the kind of man Governor Leavitt is. He will be a great Secretary. So, with pride and admiration, I introduce to this committee Governor Mike Leavitt, and I hope that this committee will help us to get him confirmed in the job as soon as possible so that this great work can go forward.

The CHAIRMAN. Thank you, Senator Hatch.

Now, Senator Bennett.

STATEMENT OF HON. ROBERT BENNETT,
A U.S. SENATOR FROM UTAH

Senator BENNETT. Thank you very much, Mr. Chairman and members of the committee. I appreciate the opportunity of being

here. You all have copies of Mike Leavitt's resume and you know his activities and his accomplishments. Orrin has outlined that.

Let me be personal with you for just a minute, as I did with the other committee. I first met Mike Leavitt when we were both private citizens worrying about the quality of Utah's schools.

The State legislature created a group to address Utah's schools, and I was part of that group. I looked across the room and said, who is that very bright, very young man—by my standards, at least, he was very young—who has all those good ideas? Someone said, that is Mike Leavitt.

Mike, I have come to realize, has had the kind of stepping-stone career that prepares you, one experience at a time, for high responsibility and high office. I think if you had just dropped him in, he would have a tremendous learning curve.

But as I look back over his career, I find many parallels with my own. He cut his teeth running his father's political career while he was in his 20s. I ran one of my father's campaigns when I was 28. The difference is, my father won and his did not.

But that had an impact on him, in that his father then took another assignment that took him out of the State, which meant that he then, as a young man, ran his father's business.

With his father gone, he then went from a political experience to a managerial experience, and then decided that he wanted to put his own name on the ballot. We became good friends at that point because we ran together in 1992, he for governor and I for the Senate.

We share the distinction, along with Senator Hatch—this may be a requirement for election—of having finished second in the Utah convention, so that all three of us had to come from behind to win the primary. But that was a growing kind of experience.

Then he served as governor, elected three times. There has been only one other governor in the State who has had that experience. I want to share this with the committee, as I did with the Health Committee, because it involves your former chairman.

As we were debating welfare reform, we all remember that Pat Moynihan was absolutely dead set against any kind of welfare reform. He took the floor saying that if we passed this welfare reform bill, we will have a race to the bottom. Everybody will do as little as possible.

Well, I had had conversations with Governor Leavitt about what was happening in welfare reform in the State of Utah under the waivers that had been granted by Secretary Shalala. She, by the way, came out and looked at the innovative welfare reform that was happening and said, this is what we ought to do nationwide. Utah is the example of what we ought to be doing under the waiver. This ought to become normal policy.

So, I ventured to disagree with Chairman Moynihan on the floor and said, I do not think welfare reform will be a race to the bottom because I have seen what Governor Leavitt has done in Utah. We have some innovative, creative things that are making welfare better. The focus is not on making welfare cheaper, the focus is on making welfare better for the people who are on welfare.

I will never forget Senator Moynihan saying, I agree with the Senator from Utah that it will not be a race to the bottom in Utah, but I guarantee you it will be in New York.

But this was a tribute to the creativity of this man. He could have stayed as the governor of Utah, probably as long as he wanted. But the President called him with a new challenge and this was a significant step up. I remember talking to him about what it was like to go from governor of Utah to Administrator of EPA. He said it is a very steep learning curve. Possibly, if he had been made Secretary of HHS straight from the governor's chair, he would not be as qualified as he is. But he has now had a year of dealing with a major Federal bureaucracy, the culture of which is entirely different than dealing with a State bureaucracy in a relatively small State.

So, I ask you to recognize that he has had a series of steps, from his first political experience, to his business experience, to his electoral experience as a candidate, then his experience as governor.

By the way, he was chairman of the Republican Governors Conference, chairman of the Western Governors Conference, and chairman of the National Governors Association, so he moved up there, then a year of experience with the Federal bureaucracy. I do not think there is anyone who comes to this with better training or better preparation.

But, as Orrin has said, just as important as that training and preparation is the character of the man. On that score, I have absolutely no doubt in recommending him to this committee with wholehearted support for this nomination and urge that we do everything we can in the Senate to get him on the job as quickly as possible.

The CHAIRMAN. Thank you, Senator Bennett.

Now we go to the statement by Governor Leavitt. I would suggest that you do not have to ask, if you have a long statement you want put in the record. I will be put in the record. We always ask people to summarize.

Before you give your statement, I have the names of family members of yours in front of me, but I sometimes leave people out. So would you please introduce any family and friends and ask them to stand, please?

Mr. LEAVITT. Thank you, Senator. I am delighted to. My wife, Jackie, is with me. Jackie is here with her mother. I might add, Senator, you responded about the progress we have made in immunizations.

There is no person on the planet more responsible for that than my wife, who worked very hard to increase. We were last, and she brought us near to the top during the 10 years that we were together. It was a personal campaign of hers and she deserves that credit.

My parents are here, my mother, Ann, and my father, Dixie. I have three of my five children that are with us as well, and their spouses. I will ask them to stand: Mike, Ann Marie, Taylor, and Tammy, our daughter-in-law. My son Westin is in Kiev, Ukraine with another brother, having quite an experience in that political system right now. Then I have a son, Chase, who is doing mission for our church in British Columbia for a couple of years. I do not

think I left anyone out. I could be guilty of the same thing you were concerned about.

The CHAIRMAN. You bet. Now, your statement.

STATEMENT OF HON. MICHAEL O. LEAVITT, NOMINATED TO BE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LEAVITT. Senator, thank you for the invitation just to summarize my statement. I will do so. I do want to express the most profound feeling I have today, and that is one of gratitude for the opportunity to have been nominated by the President, the sense of confidence that that provides.

I would like to express appreciation to the chairman, Senator Baucus, and the Finance Committee staff. They have been extraordinary in being able to help collect the information and do it in an efficient way.

I want to join all of you in expressing admiration for Tommy Thompson. I have enormous respect for Tommy Thompson. As has been indicated, we were friends as governors for many years.

We worked together, along with this committee, while we were governors on many of the same issues that we will be talking about today. He is revered by the people at HHS, for good reason. I pledge to him and to you that I will build on the legacy that he created during his service.

I would like to just tell you a couple of things, in summary, that I believe. I want you to know, I believe that public service is, in fact, a trust. Perhaps the most important thing I can tell you today is I will conduct myself with fidelity with respect to that trust.

I also want to acknowledge the fact that I believe, and feel deeply, a sense of responsibility that we all have in our society to care for the truly needy. As we do so, I believe we need to foster an ethic of self-reliance in our society, because self-reliance is a prerequisite of freedom and prosperity.

I view HHS to be, as you have said, a Department that touches the lives of every American, and many around the world. Every day when families come together and partake of a meal together, they do so knowing that the food they will eat has been inspected and safe.

In the middle of the night when we get up to administer some medicine to our young daughter or son, we do so with a sense of confidence and trust. We, among all the nations of the world, can know that that which we give them will be for their good.

It is clear to me that this Department has a profound impact on health care, both at the policy level and directly in the lives of millions of Americans. I personally have experienced, as governor, the responsibility of administering our highest and most noble aspirations as a society in helping with the welfare system and with the health care system.

I am also aware of what an important role HHS now plays in our newest challenge as a country, and that is homeland security.

Just a couple of views on what I see as being priorities. They match very closely with those that you have mentioned. Medicare. Successful implementation of the Medicare Modernization Act will be the main event at HHS during 2005. The expectations are very

high. The time frames are short. There will inevitably be flaws, but we will not fail.

I would like, as well, to add my enthusiasm for working with this committee on the reauthorization of TANF and the Welfare Reform Act that we worked on together some 6 years ago. I believe it is a great American success story and one that we need to build on. We can refine, and build, and improve, but we do need to move forward with reauthorization.

Medicaid. Medicaid is a vital program, but it is not meeting its potential to do good in the lives of this Nation's poor. We can, in fact, use those resources more wisely. I believe we can use those resources to expand access to the truly needy in this country so as to begin to move away from the large number of our citizens and colleagues who have no health care.

I would like to mention the FDA, the CDC, and NIH. Those are three names of trust in this country. They are brands. A brand is a promise. In the middle of the night when we get up to administer medicine to our child or to take it ourselves, we do so knowing that we are administering something we can count on. We cannot allow those American treasures to be lost. Protecting their integrity, I believe, is a vital and important part of this job.

Several of you have mentioned in our visits the importance of the health care discussion that we are now engaged in. Senator Baucus mentioned the fact that we are now approaching 15 percent of the Gross National Product of this country being allocated to health care.

This is no longer just a health care issue, it is an economic issue. It is about being able to assure that we maintain competitiveness in the world and care for the needs of our citizens.

I believe we are moving toward what I would characterize as a large-scale discussion on the health care system in this country, and I welcome the discussion. It needs to be rigorous. We cannot be timid. We need to be bold and transformational.

I would also comment on the relationship of the United States to the rest of the world, and pledge that, if I am confirmed, I will work to make the United States an influential humanitarian voice in the world.

When I started my public service, Mr. Chairman, I pledged to the people of Utah, and I would pledge to all of you, three basic personal goals.

First, perhaps consistent with my western roots, is to leave it a better place than I found it, to plant seeds that will be there for a future generation in full harvest, and then to give it every ounce of my energy. That is my commitment, and has been through my public service.

Mr. Chairman, I look forward to working with you and other members of the committee, and I now look forward to receiving your questions and doing my best to respond.

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

The CHAIRMAN. I thank you for your statement and your commitment to public service, and the promise that you made to the people of Utah that you have repeated here for the people of this country, and for your hard work.

We start out with three questions that we ask everybody.

The first is whether or not there is anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Mr. LEAVITT. No.

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

Mr. LEAVITT. I know of none.

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

Mr. LEAVITT. I do.

The CHAIRMAN. Thank you.

Mr. LEAVITT. Senator, I should make mention of the fact that, in the materials that I have submitted to the committee, I reflected certain of my personal assets that potentially could. I am now working with the Office of Government Ethics to resolve those, and have made commitments to do what is necessary to assure that those are cleared.

The CHAIRMAN. All right. Thank you very much for your transparency.

At this point we will start our 5-minute rounds of questioning. I would ask, at least on the first round, that members stay within the 5-minute period of time, meaning if you ask your question within the 5-minute period of time, the governor's answer on the 6th, 7th or 8th minute does not count against you.

We have got plenty of time here this afternoon, so if people need more time to ask questions, we will get that job done. But at least for those that just want one round, we will not be infringing upon other people's freedom.

So, would you start the 5 minutes, please?

As you know, in 2002, Secretary Thompson approved a waiver that allowed Utah to extend Medicaid coverage to 25,000 uninsured adults, while reducing benefits to existing adult Medicaid recipients. The Utah waiver is relevant, because your experience as governor will no doubt guide you as Secretary.

In addition, Congress and this committee will be taking a closer look at Medicaid to see if we can make improvements. It is going to take some creative leadership to slow the growth of Medicaid spending.

You have testified before this committee that you opposed caps on Federal Medicaid spending in any form because it shifts costs to State and local governments that they cannot afford. That would be March 11, 1997 testimony before this committee.

You also stated that the cost shift that would result from a unilateral Federal cap would force States to choose between cutting back on payment rates to providers, eliminating optional benefits, ending coverage of optional beneficiaries, or coming up with additional State funds to absorb the cost, the same reference.

Question. As we look ahead to the challenges that we must face with the Medicaid program, would you please discuss your vision for improving Medicaid, and also your vision for SCHIP? And would you also discuss what role you believe private insurance cov-

erage should play in providing health care coverage to lower income individuals and families?

Mr. LEAVITT. Senator, let me speak directly, that I believe—as I did then—that mandatory populations should remain mandatory and that optional coverages and groups should remain optional. My view has not changed on that matter.

With respect to the waiver that you alluded to, first, let me indicate that the waiver was not intended to show the way of any large-scale, national approach. It was designed to solve a problem that I uniquely felt as governor.

Here was the problem. I had 400,000 of my fellow Utahns who had no health insurance. In Utah, if you desire to have the richest health insurance benefit plan in the State, you will go on Medicare. If you choose to have the second richest health insurance benefit, you will go on Medicaid.

If you are on Medicaid in my State—I do not know what it is in other States—you are somewhere between 35 and 40 percent richer in benefits than you would be if you were on a plan in the private sector. So we made the decision to try an experiment.

With the acquiescence and support of HHS, we looked at some optional groups and made some modifications in the benefits, took the savings, and created a small, for lack of a better term, HMO out of our Primary Care Network.

We created a small policy that, in essence, provided basic care benefits and provided basic preventative health care to roughly 18,000 people in our State who had no coverage. We, in essence, were able to use the money we had to extend benefits to a very significant population of people who had none.

Now, at the same time, we made clear, and I made clear, that I do not see that benefit package as being what I would aspire to have the average Utahn provided. We went to the hospital community in our State and said to them, will you help us provide more than just preventative care? Our hospitals committed nearly $10 million to provide extended care and specialists to this population.

I would suggest, it has been a very successful experiment, one that I have learned from and that I believe others could learn from. Is it perfect? No. But we have provided health care to 18,000 people who had none.

The CHAIRMAN. Do you still oppose caps on Medicaid programs in any form?

Mr. LEAVITT. Mandatory populations should remain mandatory. Optional coverages should remain optional. Optional groups should remain optional. That was the position I had when I made the statements you referenced, and that is the position I have today.

The CHAIRMAN. What tools can the Federal Government give to the States so they can better manage spending while providing access to quality health care?

Mr. LEAVITT. Senator, greater flexibility. I firmly believe that States, given the tools to manage health care, cannot just improve the quality of the delivery, but they can also expand basic quality health care to more of our citizens.

You asked about SCHIP. That is another example of where I believe we use some ingenuity and innovation to provide high-quality health care to our citizens. SCHIP includes a provision under

which States can provide or create a program of their own as opposed to adopting Medicaid.

We opted to that provision. We concluded that we would provide our children essentially the same coverage that my children have, or had, as governor. Instead of adopting Medicaid, we opted to put them into the program, and we were able to cover 35 percent more children.

Now, granted, it was not the same coverage as Medicaid. It was the same coverage that the governor's children had. I am not suggesting that that is perfect, but 7,000 children who had coverage who otherwise would not have, in my view, was a success.

The CHAIRMAN. Thank you very much.

Now, in this order: Senator Baucus, then Senators Hatch, Rockefeller, Snowe, Conrad, Thomas, Bingaman, Smith, Wyden, Kyl, Lincoln, and Bunning. If some of you feel that you were not seen at the right time, take it up with the administrative staff, because you will not make me mad if it is wrong. Just, do not sulk away.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Leavitt, you and I have had several discussions lately with respect to information and data from HHS. As you know, I have a concern on the drug bill. That is, how is the $1 billion that Congress has allocated to the implementation of the drug benefit being spent? That is a lot of money.

Frankly, I would like to see the drug benefit work. I know there has been a lot of controversy around it. You did give me some data, albeit pretty sketchy, which, to be honest, leads me to conclude that not nearly as much hard thinking has gone into how to spend that $1 billion effectively as there should be. I would like you to comment on that.

I have another couple of questions during my 5 minutes, if you could comment on all three questions at once.

The others are in respect to the administration's policy with respect to inter-governmental transfers. As you know as a former governor, States are very ingenious in finding ways to ramp up their State match in order to get more Federal money, and then they take the money out of the State match and it goes back to where they got it in the first place. We have had problems with upper payment limits, and Congress has tried to address that.

I would like to know the Department's position, not only its policy with respect to inter-governmental transfers, but I would like to know whether the Department is going to issue rules or general guidance as to what is a proper transfer and what is not a proper transfer, not on an ad hoc basis, but just so we all know what the rules are. And if not, why not.

The same is somewhat true with respect—and you have given me a lot of this information—to the drug discount cards. That is, what is the State-by-State experience? How many people are enrolled in these drug discount cards on a per-State basis?

You have given us information, as I requested, for the States represented by members of this committee, but have not thus far with respect to other States, although you have given us some unscrubbed data with respect to other States.

I frankly would expect that data to be given to us very quickly. I understand that data will be scrubbed and given to us sometime next week, I would hope. The earlier the better.

If you could just comment on those three points. Actually, I will give you a fourth question to address while you are thinking about the other three. Again, with respect to Medicaid.

If you could tell us, you have said already that you oppose per capita spending caps for mandatory spending. The question is, do you oppose or not oppose per capita spending caps for optional populations? Those are the four questions.

Mr. LEAVITT. With respect to the first on Medicare and the $1 billion, you referenced our conversation about Medicare. For the others, I will say that, shortly after the time I became governor, we were successful in obtaining the Olympics.

I knew at that point I had 7 years to prepare and to do it well. I also knew that it probably did not matter a lot what else happened in the next 7 years, if we did not do that well, that would long be remembered.

I feel the same way about the Medicare roll-out. I know that it has high expectations, that we need to invest that $1 billion well, that we need to assure that seniors, particularly the Medicaid population, transfer efficiently.

What I can give you is my certainty that I will personally become involved in that. I want it to do well. I think the legacy of this committee, the legislation, the President, all of that is important. That is an important element of it.

Second, with respect to inter-governmental transfers on Medicaid, this partnership has to be one of certainty and integrity. In the next 10 years, we will spend $5 trillion on Medicaid. I have a hard time even contemplating that number.

We need to have what I believe will be an awkward and somewhat sensitive conversation with some of our State partners. Most of the States, I believe, are dealing with it in a straightforward way. Some are using transfer techniques that will likely need to be reviewed, and I commit to do that.

Senator BAUCUS. I think it would be helpful if there were some definite guidelines, some rules, a comment period, so it is not ad hoc.

Mr. LEAVITT. I agree with that. We need certainty and we need real commitments with real dollars.

Senator BAUCUS. Thank you.

Mr. LEAVITT. Third, with respect to the numbers on the cards per State. We are committed to do that. My influence at HHS is only informal right now.

Senator BAUCUS. Oh, it is pretty strong right now. [Laughter.] I think you have a lot of influence.

Mr. LEAVITT. I am hoping it will grow today.

Senator BAUCUS. Oh, you have got the juice. You are there.

Mr. LEAVITT. We are committed that, by mid-week, those numbers will be scrubbed and to you.

With respect to Medicaid and the populations, my position is as it has been. Optional coverages optional, mandatory, mandatory. There are currently in the Medicaid program——

Senator BAUCUS. Should there be caps on optional? That is my question.

Mr. LEAVITT. Senator, I do not see changes at this point, in that I do not know what the administration is thinking, in precision. I do know that there are limits now.

Senator BAUCUS. I am asking you your view. You are the Secretary. You are the one before us today.

Mr. LEAVITT. Well, my view is that mandatories remain mandatory, optionals, optional. I believe that, within the context of that, we can manage what we have better. We can, in fact, expand access, and at the same time we become more efficient.

Senator BAUCUS. We have got to help people who need help, frankly, and that is what this comes down to.

Mr. LEAVITT. The waiver that we talked about earlier, where I was able to take an existing amount of money and expand it to 18,000 people. Frankly, Senator, that is based on a long-held belief I have that this society needs to provide high-quality basic health care to its needy and that we are better to have all who have high-quality basic health care than a few who have a benefit package that is unmatched by anyone else in society. What I am looking for is a way to expand access of basic quality health care to more people, and I believe we can do that. I think we can do it more efficiently.

Senator BAUCUS. Well, my time is up. I would like you to also look at other ways, frankly, from an administrative way, to expand Medicaid, expand CHIP, and various ways to get more people covered.

Mr. LEAVITT. I believe it will be a function of many different approaches. This is not something for which there is a simple mold.

Senator BAUCUS. Right. And some have talked about tax credits. I am open to it all, but we have got to chip away at it. No pun intended. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Now, Senator Hatch.

Senator HATCH. Well, thank you, Mr. Chairman. I just want to compliment you again. Governor Leavitt, we are so grateful to have you in this position, and I know you are going to do a great job.

I do not know of anybody who loves policy more than Mike Leavitt does. He works at it, and works at it, and works at it. I think you will all enjoy working with him, as I have in the past.

Let me just say one thing. There are a lot of things I would like to say, but let me just say one other thing. While the Medicare Modernization Act increased Medicare reimbursement for physicians in 2004 and 2005, unless action is taken this year, physicians who participate in the Medicare program will see serious reimbursement reductions in Medicare payments next year. In fact, doctors will face significant Medicare payment reductions that, by 2013, will total 31 percent and will threaten Medicare beneficiaries' access to care.

You and I both know John Nelson, who is president of the American Medical Association and, of course, is an OB/GYN in our home State of Utah. But he raises this standard with me every time I meet with him. I agree with him that something needs to be done.

We in Congress, and many of us on the Senate Finance Committee, have made this matter a high priority, and we appreciate working with you on resolving this issue once and for all. So, you might keep that in mind.

On the CHIP bill, as you know, I am the author of the CHIP program. You were governor of Utah at the time. We spoke many times about how this could better be done, and I think in the end we got it right, to the extent that this body can get anything right. So, I want you to keep watching over that, because I think that has done a remarkable job of helping our children.

Mr. Chairman, I have to go to the Treasury Department because a former staffer of mine is being sworn in as Treasurer of the United States. I am going to try and get back as soon as I can. If I do not get back, I want you to vote me for Governor Leavitt. But I intend to be back in time to vote. So, forgive me for having to leave.

And, Governor Leavitt, if you will forgive me for having to leave. I know the people on this committee are going to treat you very well, and I would expect nothing less. So, we are grateful to see good people like you in government, and good wives like you have who stand behind you and back you up in the way that you are going to have to be backed up, because this is an all time-consuming job. Jackie, you might as well know, this is an 18-hour a day job. Even then, you cannot do it all. But if anybody can, you can.

Mr. LEAVITT. Thank you, Senator.

Senator HATCH. So we will help you up here. You have a wonderful committee here. These are really good people, and we do work in a bipartisan way, in most ways. Hopefully, we can do a lot to help you in this job, and I will be doing everything I possibly can to help you.

Mr. LEAVITT. I look forward to working with you.

Senator HATCH. Thank you. We appreciate your willingness to serve.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Now, Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Governor, we certainly do welcome you. There is an interesting discussion already, and I think Blanche will agree with me, that there is a little problem developing here with respect to supporting the mandate of Medicaid, but then when you get into something like the CHIP program or some other population, pregnant women, children, all different kinds of populations, that it becomes, in fact, optional, in your view.

You started out by saying, in 1997, as governor, you were against all of this. Then in 2002, you said, well, you supported a cap on Medicaid spending. I do not know if you elaborated at that time, but that is a change. Now, we all understand, you were not in health care at that point.

I spent all morning at the Defense Intelligence Agency. Everybody in this country thinks the Defense Department, with a worldwide obligation, has the biggest budget. You have, by far, the biggest budget in the Federal Government.

So the question of how you treat Medicaid and some of the programs underneath it—for example, what are we going to do with the capped funding question? You capped funding in Medicaid. As Orrin Hatch began to talk about, you affect doctors and hospitals, long-term care, nursing home facilities. You have these enormous events.

It is very easy for us in Washington to throw out, kind of, views of life, I favor this. But then when it comes down to the States, what, in effect, I think you are saying, is that even though Medicaid is 10 percent cheaper, 8 percent cheaper than private plans, it is almost 4 percent cheaper than Medicare over the last 4 years, according to CBO.

It will have a cap where it affects optional programs or populations. Therefore, what you are saying, is we must be creative, which is a good statement. Nobody can argue with that. But the bottom line is, it will be up to the States.

Now, I come from a State called West Virginia, which is neither as large, nor nearly as prosperous, as the State of Utah. We are struggling mightily to make the CHIP program work and to cover Medicaid. It is by far the largest expense, most rapidly growing expense, in the State.

I cannot settle, from my point of view, if it is an optional population or an optional program; no, we will figure out a way to do it, which means basically the States will have to pay for it. Our State cannot. They will simply drop population. You have got 7,000 more kids covered. That will not work in our State. They will lose coverage.

So I really want you to explain a little bit more in depth to me the tricky relationship between, I do not support a cap on Medicaid, but we have got to figure out how to create other ways of doing things for optional populations and optional groups.

Mr. LEAVITT. I would be happy to respond to that. Senator, my experience, when I became governor in 1993, is we engaged in a State-wide, rather rigorous discussion of the whole topic of health care, generally, and developed a comprehensive approach to health care and providing access that we incrementally wanted to move over a 10-year period to enhance that access.

I had the great privilege, the rare privilege, of being able to work on what we called our Health Print from the first day until the last day, virtually a decade, and we made serious progress.

Some of that progress came because there were optional groups and optional benefits that we were able to add at various times as we had the capacity to do so. We opted into the program early on, before I was governor, with basic, mandatory coverages and basic, mandatory groups.

Then, as we had the capacity, we added the optional benefits. We added the blind, the aged and the disabled. We added certain benefits, vision and dental plans, to various groups as we had the capacity.

Now, in the year 2002, our State was under severe economic distress, as were many other States, I trust West Virginia being one of them. In order to balance our budget, in order to be able to continue to provide education to our children, we made a decision on a small group of optional groups to reduce one of the optional pro-

grams. It was a management tool we had to use in order to make our budget balance. To me, that was an unhappy moment.

I might add, it was the same year that we then chose with another group to take a dollar of co-pay more, to put some limits on one other, and to expand coverage to 18,000 people.

When I talk about this, I am looking for the flexibility that a manager of health care delivery has in any other circumstance. When I talk about flexibility and the ability to manage the options, that is what I am talking about. I am talking about being able to take the resources we have available to us in States and deploy them in a way that will expand access to the most significant group of our citizens.

Now, I will acknowledge the fact that, right now, Medicaid does not provide that. I believe Medicaid is not efficient. I do not think it is meeting its potential to serve the poor. We are not looking to take those dollars and deploy them into highways. We are not talking about being able to take those dollars and deploy them into education.

Senator ROCKEFELLER. But it is more efficient than Medicare. It is more efficient, by far, than private plans. I just question whether what you did in Utah sort of says, well, then we can do this in America. I would suggest to you, in Appalachia and a lot of other areas of our country, New Mexico and others, there is a very, very different situation.

I would urgently hope that you would think about this matter now that you really have the entire country's populations—pregnant women, children, different groups—very much at your mercy, or at your help. As you said, you want to leave the world a better place.

Mr. LEAVITT. Senator, I can tell from our brief exchange here that there is the makings of a very good policy discussion between us. I would like very much to have that. I think the goal here is very clear: let us provide basic, quality health care to the largest number possible. What I seek are the tools necessary to do that, to accomplish it, and I hope we can work together to accomplish that very, what I think noble, task.

Senator ROCKEFELLER. So do I. Thank you.

The CHAIRMAN. The next person is Senator Conrad. No, I am sorry, it is Senator Snowe.

Senator SNOWE. Thank you, Mr. Chairman.

I want to welcome you, Governor Leavitt, to this committee, and your wife Jackie, and your entire family. We certainly want to wish you well in your endeavors, because I certainly believe that you are uniquely qualified to lead this Department, certainly with the depth and breadth of your experience previously as governor, understanding many of the problems that governors are confronting in balancing their budgets and meeting constraints and mandates from the Federal level, as well as your experience currently as Administrator of the EPA.

The Department that you have been nominated to lead certainly has challenges that are immense, as well as complex. I think one of the greatest challenges we are obviously going to face, and I think you recognized that in your statement, was the implementation of the first-ever National Prescription Drug Benefit program.

One of the associated challenges with that program is ensuring that there is affordability of prescription drugs, because frankly, in the final analysis, if we cannot address the issue of costs of prescription drugs, it is going to negate the value of the overall benefit.

I know that you said yesterday, in response to questions about whether or not you will be able to keep the costs within the $400 billion, which was the original price tag, obviously, for the prescription drug benefit, you said that is your practice as a manager, to act within your budget.

Well, you will need those managerial tools and talents to contain those costs without question. That is why it is so difficult to understand why there has been such resistance to the notion of drug importation, as well as bargaining authority.

To start with bargaining authority, my colleague Senator Wyden and I have introduced legislation in the past. We plan to re-introduce it shortly to give you the authority to be able to negotiate prices.

Currently, the Department of Defense and VA have more authority to negotiate prices, Blue Cross/Blue Shield has more authority to negotiate prices, but the Secretary of Health and Human Services does not, even in spite of the fact that CBO has indicated that there will be cost savings, particularly with sole-source drugs because there are no equivalent competitors; that DoD and VA have already demonstrated that there are savings. So, clearly, we need to be able to give this tool to the Secretary.

So, I would like to get your response to that question. In fact, Secretary Thompson indicated that he wished he had had the opportunity to have this prerogative as well. And certainly that is going to be central to helping the benefit to be implemented by controlling the cost of prescription drugs, which is now increasing at two and three times the rate of inflation.

Drugs, if they are not affordable, cannot be effective. In my State, just recently three individuals were hospitalized because they could not afford medications. So, I think that the Federal Government needs to use every tool available to negotiate lower prices and to be in a position to leverage lower prices.

Mr. LEAVITT. Senator, with respect to the issues on re-importation, which I believe is, in large measure, an economic concern, but it is also a safety concern. I think I have indicated, and I am sure there is agreement, that if in fact they can be done safely, then it is a discussion we should be having.

With respect to the Secretary having the capacity to negotiate, I know very little about that issue, so I am going mostly from instinct here. My instinct tells me that it is an open and rigorous market that ultimately produces the best outcome, and that the negotiation in a marketplace takes place between those who use or distribute and those who manufacture.

There are times in which the national government sits in that place and should play that role. There are other times when we do not, and we should be quite cautious as to not become the setter of prices as opposed to a player in a market. To the extent that we could accomplish that, I believe those are the parameters.

Senator SNOWE. Well, I appreciate that. I hope we can have that conversation regarding that authority because I do think it is very critical to this entire debate. I think drug safety and affordability are not mutually exclusive issues.

It is further disappointing and disturbing that we have not been able to implement the importation law that has been passed three times now in two different administrations. Recently, Senator Dorgan and I, in the last Congress, introduced legislation to systematically address many of the concerns of the recent Health and Human Services Task Force.

All eight concerns have been addressed in our legislation regarding safety and reliability. We hope to reintroduce that legislation again, incorporating other views as well from among our colleagues.

But, again, it is hard to understand the resistance and the intransigence of this single question. In fact, the cover letter by the previous Secretary to this report indicated that we could adopt wholesale high-volume importation from Canada only, which places greater pressure on Canada.

Our legislation does not rely on Canada only, so it does not place inordinate pressure on them to provide or supply to the more than 2 million Americans who import drugs, but also allows imports from 19 other countries with whom we share equivalent safety standards. We have asked some of those countries for flu vaccine.

So, it clearly does not make sense as to why we cannot adopt this legislation that addresses the safety questions, the reliability questions, and give people what they deserve, which is a much more affordable prescription drug that they, heretofore, cannot support financially.

Mr. LEAVITT. I had a fruitful conversation with Senator Wyden earlier today, where he indicated that he would be active on this, along with you. It is an issue, frankly, that I am anxious to learn more about.

I have read conflicting views on the economic impact of reimportation. I do not know how to interpret that. The safety concerns, very clearly, would be squarely on my desk if I were to be confirmed as Secretary, so I need to dig deeply into that. I look forward to that discussion with Senator Wyden, and also with you, and understanding better what the economic impacts, in particular, are.

The CHAIRMAN. Now, Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman.

Welcome, Governor. It is good to have you here. I also want to welcome Senator Wyden to the committee. He is a very good addition to the Finance Committee and we are delighted that you are here, Senator Wyden.

And, Governor, we are delighted that you have been nominated by the President for this position. As I told you privately, I have high regard for you. I have watched your career. I remember the first time I was ever exposed to you. You were on "Meet the Press," or "Face the Nation," or one of those programs.

I thought you really stood out as somebody who is rational and reasonable. I think every experience I have had with you has con-

firmed that judgment. So, I look forward to supporting your nomination.

Mr. LEAVITT. Thank you very much, Senator.

Senator CONRAD. And I thought you did a very good job. I know there are differences. In my interactions with you at the agency that you have headed, I have found you very responsive and reasonable, and that is important in these positions.

With respect to Medicare, we have a lot of discussion going on in the city and around the country on the need for Social Security reform. Indeed, we do have a challenge, long-term, with Social Security.

The truth is, we have an even bigger challenge with Medicare. You and I discussed this the other day. It is really a much bigger long-term problem. I think the sooner we get about addressing that, the better.

I think one of the things that strikes me as a big opportunity, is 5 percent of Medicare beneficiaries use 50 percent of the budget. Five percent use 50 percent. If we look at those chronically ill, we have a lot of opportunity here to focus on them, to provide better health care outcomes, and to reduce cost.

One of the things we have learned is, if we have a case manager, a nurse or somebody else in the health care profession, follow those cases, we can dramatically reduce the number of prescriptions they are taking, because many of them are inappropriate, and leading to hospitalization. So, this is a big opportunity for us, and I think we need to focus on it.

In the prescription drug bill that passed, there are a number of provisions that are included. I authored a number of amendments that were passed on the Senate side that, unfortunately, were not fully included at the end, but some of them were, and I hope that we pursue those actively and aggressively.

I wanted to ask you specifically about the estimates on the prescription drug bill. We were told at the time the legislation passed that it would cost roughly $400 billion, a shade above $400 billion. Then we found out there were internal estimates that the bill would cost over $500 billion. I think they settled on about $534 billion.

It has disturbed me ever since, as Ranking Member on the Budget Committee, that if we were misled, that is a very serious matter. In fact, I believe we were misled. I believed those estimates.

I could not have written a budget with a $530 billion cost. I could write one with a $400 billion cost that I thought was responsible. I could not write one at $534 billion. Frankly, it would have changed my vote had the information been available to us.

I would, first of all, like to know your assessment of what happened and to get a commitment from you that this would never happen again, that the full information that is available to you as the Secretary would be available to members of Congress who have to vote on legislation.

Mr. LEAVITT. Senator, you raised three topics. I will comment on each of them. You mentioned, in passing, my time at the Environmental Protection Agency. May I just tell you that I hope, and have confidence, that the Agency is better off because I spent time there.

But I want you to know that I am better off because I spent time there. I was exposed to some of the most remarkable professionals I have ever worked with who cared deeply about their subject matter and who work hard to do it, and I have been appreciative of that opportunity.

With respect to Medicare and the long-term commitments that we are making, perhaps I can best reflect by just a brief story.

Jackie and I, each year while I was serving as governor, would invite the centenarians to visit the governor's mansion. Anyone who had achieved 100 years of age or more would come. It was a grand event every year. They would come with their families, and we would have brunch and tell stories and laugh. Every year, there were great things that came from it.

But the last year we had the privilege of doing that, a man from the Aging Division of the State stood and said, this year we invited 138 people from the State who have achieved 100 years of age.

Today in a hospital not far from here, a little girl will be born who will have a 50 percent change of being invited to this gathering 100 years from now. We will invite 10,000 people to the centenarian brunch 100 years from now.

Every one of those will ultimately be part of the trust we have on Medicare, and it gave me a solemn and rather sobering view of that challenge.

With respect to the estimates, may I say I have little I can add to this conversation. I was not part of it. But I can add this, that I believe the best public policy is that which is informed by facts. You have my commitment to do my best in being able to provide facts when I have them, and when I do not, to tell you I do not.

Senator CONRAD. I appreciate that.

Might I ask one question in conclusion, Mr. Chairman?

The CHAIRMAN. I hope it is a short one.

Senator CONRAD. Very short.

That is on the question of Medicare reimbursement for rural hospitals. You as a governor recognized this inequity. We have faced, before the last legislation that was passed, an enormous inequity. A hospital in my State would get one-half as much to treat a pneumonia victim as a hospital in New York, $4,200 in North Dakota to treat that patient, $8,500 in New York.

I authored a series of provisions, along with other members of this committee, that are in the legislation that has passed that begin to level the playing field. But they expire in 2006 and 2007.

I would like very much to get your commitment that you will help us work on extending those provisions to increase the fairness of Medicare reimbursement to these rural institutions.

Mr. LEAVITT. It has become evident to me, from my conversations with you and other members of this committee, that our greatest level of statesmanship will be required on this issue.

There is a lot of challenge, and I know that, as a person who has been governor in a State that had a concentrated urban area and, as well, rural areas. I have heard from almost all of you about this issue, and I will do my best.

Senator CONRAD. I thank the Chair.

The CHAIRMAN. Thank you.

Now it is Senator Bingaman, and after Senator Bingaman, Senators Smith, Wyden, Kyl, Lincoln, Bunning, Crapo, and Lott.

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

Governor, welcome. I look forward to working with you in this new position. I am sure you will be confirmed with a very strong vote, and I will be joining in that.

You do make one statement in your prepared statement to the committee today that caught my eye. You say, under the section on Medicaid, that "Medicaid is flawed and inefficient."

I just wanted to hand you a copy of some sheets there that I wanted to be sure that we were in agreement on. This first sheet talks about average spending growth per capita between 2000 and 2004. If you look at employer private sector, the average spending growth per capita is 12.6 percent. Under Medicare, it is 7.1. Under Medicaid, it is 4.5 percent.

That does not mean to me that it is that inefficient as compared to those other two categories. What I believe has happened with Medicaid, is that you have Medicare picking up more and more of the cost of long-term care.

It is the payor of last resort for many people who need some type of long-term care, so the population shift, the number of people in Medicaid has gone up, the number of people requiring long-term care has gone up, and that is why the costs keep going up.

So, it is not the inefficiency of the system, it is the fact that we do not have any policy for providing long-term care in the country. We never have had. There is no effort that I know of to provide such a benefit to anybody. Accordingly, it all falls on Medicaid to do it.

I would be interested in your reaction to that and whether you agree that, really, the focus, if we are serious about reform of Medicaid, ought to be on reforming the long-term care system for the country so that we do not just have more and more people going into Medicaid to get that benefit.

One other thing I would mention, is that Senator Smith and I have co-sponsored a bill to establish a commission to look at Medicaid and find proposals that would help Medicaid serve the public better. I would be interested in any comments you might have on that.

I think I mentioned that to you when we had a chance to visit before as something I think would be a very constructive step in developing some kind of bipartisan approach to solving our Medicaid problems.

Mr. LEAVITT. Senator, I have only had a chance to glance at these, but let me just give you some top-of-mind responses.

Senator BINGAMAN. Please.

Mr. LEAVITT. The first thing that jumps out to me is a bias and a feeling that I hold deeply, that the entire system of health care in our country is inefficient, that we can dramatically improve it. We will not do so by fussing around the edges. We will have to be bold and, I believe over the course of time, transformational.

I believe technology is at the heart of that opportunity and that we can, in fact, effect it as a national government, not just in terms of our policy, but in the way we manage Medicaid and Medicare.

The second point. I do not know the extent to which these numbers reflect the rather significant pressures that States have been under in terms of their Medicaid financing. That may, in fact, bear on this, but I do not want that to diminish from the point I think you are making that is absolutely true. That is, that long-term care is, in fact, the most significant challenge we face, both in Medicaid and in Medicare.

I point to what I see as an interesting laboratory on this subject in the States of New Hampshire and Vermont, two very similar States, side by side, and one would have to argue, very similar cultures, very similar topography and demographics. One has concentrated its efforts on being able to provide home health care for long-term care, the other has not.

Vermont uses about 15 percent of its Medicaid dollars for long-term care. New Hampshire, on the other hand, is at 51 percent. It is nearly twice as expensive. I believe that is the kind of thing we need to look for as a means of being able to find solutions to what I believe you have nailed as being the big culprit in the future.

Senator BINGAMAN. No. I would agree. I appreciate that answer very much. It is my view that States need to be able to provide home- and community-based coverage without going to you or the Department for a waiver. I mean, I think that is something that we ought to legislate here. I think the administration ought to support it.

As I understand the law today, States can let more people into nursing homes, and Medicaid will pick up the tab. If they want to provide services at a person's home, then they have to go to you for a waiver. That seems to me just backwards.

I am not suggesting that they have to get a waiver for folks going into nursing homes, but they certainly should not have to get a waiver from the Federal Government in order to do what you are saying has worked so effectively in Vermont and New Hampshire.

Mr. LEAVITT. That is a very good illustration of something I heard Senator Baucus also express a concern on. That is, the way we are using 1115 waivers.

Now, I want to say, I have been the beneficiary of them. I believe they are a good tool for innovating and solving specific problems. They clearly ought to be used inside the law, and be transparent.

But there are certain of these subjects that we ought not to have to do waivers on. We had, in the State that I governed for 11 years, a State nursing home program where we could do it with solely State dollars, but it was, frankly, quite limited by the capacity we had to fund it.

But the fire power we gained in being able to deliver services with those limited dollars were dramatically leveraged by the goodness of people who wanted to care for their family members. Those centenarians that I spoke about that came to our celebration, they were all surrounded by their family who cared for them.

Now, I know that there were some of them that had to be cared for in institutions, but for the most part, there was family who cared, and wanted to care. I am a deep believer that that is not just valuable, but it is good for the soul of those who do it and we ought to be enabling it.

Senator BINGAMAN. My time is up, Mr. Chairman.

The CHAIRMAN. Senator Smith?

Senator SMITH. Governor Leavitt, I want to join the chorus of your family, friends and admirers who sing your praises. I look forward to voting enthusiastically for your confirmation.

I also want to welcome my colleague, Senator Wyden, to the Finance Committee and know that much good will come of our bipartisan efforts here on behalf of health care and many other issues before this committee.

Governor, to Senator Bingaman's point, Senator Harkin and I have a bill called The Money Follows the Person that goes to the very thing you are talking about, and I would commend it to you. In fact, I believe the President has expressed support for it.

Also, to another point Senator Bingaman was mentioning, he and I are about to introduce a bill that proposes a Medicaid commission, a bicameral, bipartisan commission that would study Medicaid before we begin to do things that, frankly, we might regret. We have had commissions on Social Security, taxes, and about every other issue around here, but I am not aware of one on Medicaid.

I wonder if you would agree that passing a budget or funding changes that cut Medicaid should not happen until there has been a Federal and State discussion on this. I fear that time is running out.

Do you have a feeling about that?

Mr. LEAVITT. Senator, I have expressed, I think, in a robust way my belief, that changes need to be made in Medicaid and I am anxious to see them occur. I am anxious to see them occur as quickly as they can. I am not in a position to comment on behalf of the administration with respect to their position on the specific bill that you offered.

If I could mention, however, there is a need, in whatever forum, for a rigorous discussion on the kind of flexibilities that Senator Bingaman referenced, and the long-term care issues.

I mentioned earlier that I believe in the need to have a sensitive, somewhat awkward, but very important discussion with the State partners about real commitments and real dollars. All of that needs to be a discussion, and some of it needs to happen fairly soon. So, I would only say, let us have the discussion in whatever forum. There is a full agenda.

Senator SMITH. I am sure you are hearing from your colleagues, the governors, how much anxiety there is on this issue.

I apologize for having canceled our meeting. I did not want to share with you the symptoms of the flu.

Mr. LEAVITT. We had our own little epidemic of that at the Leavitt home. I successfully report our conclusion.

Senator SMITH. Well, given what happened with the Shearing Corporation in Britain, I wonder if your Agency is taking some leadership in making sure we do not have a flu vaccine shortage next year.

Mr. LEAVITT. Of course, when the President asked, I began reviewing quickly the things I might confront, this being one of them. What I would say, Senator, is I fully recognize the seriousness and the potential danger that exists from a nation not prepared for this. I believe there are many things that can be learned from our

experience, and I am resolved both to learn them and to implement those lessons.

Senator SMITH. I believe Senator Wyden will probably raise the TANF issue with you, so I am not going to spend time on that. But Oregon, like Utah, has been a real innovator in this issue and we need your help and understanding on this reauthorization.

An issue close to my heart for family reasons is the whole issue of mental health. You and I spoke about the Garrett Lee Smith Memorial Act and my hope that the administration will continue its remarkable support in the passage of the legislation and its initial funding. I hope that you will help focus on that as well and help us pass full funding for this next fiscal year.

In addition to that, I am one of the Republicans who actually is enthusiastic about mental health care parity and believe it is important we bring this issue out of the shadows and help people understand mental illnesses can be just as lethal as physical illnesses. Until we understand that and address it in our law, I think we are taking care of half the equation. I do not know if you have a comment on that.

Mr. LEAVITT. I am going to express agreement on both points.

Senator SMITH. In fact, I do believe that President Bush has also expressed his support for mental health care parity. So, I see my time is ending. I will just conclude by saying that, under the TANF reauthorization, Oregon has had some remarkable success in crafting individualized kinds of programs for people on welfare and getting them to work.

But timing is an issue and enough flexibility is an issue to bring about the kinds of success stories that they can tell all day long. So, I really do hope that, as we go to reauthorize this, that States will be given the flexibility to be pioneers in this area.

Mr. LEAVITT. Thank you. That is a discussion I will enthusiastically involve myself in, whether it is raised by Senator Smith or Senator Wyden.

Senator SMITH. Thank you, Governor.

The CHAIRMAN. Next, is Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. I just want to express my appreciation to you, Mr. Chairman, and to Senator Baucus for your gracious welcome, and to think that somebody who is the director of the Gray Panthers could have a chance to work on this committee in a bipartisan way is just an extraordinary thrill. I just want to express my thanks to you, Senator Smith, and other colleagues who have been so welcoming, Senator Snowe, Senator Lott, and others.

Governor, you are eminently qualified for this position. I am going to be supporting you, and supporting you strongly. I just want to use this, almost by way of starting the teaching, I think, that we are all going to be going through to tackle this in a bipartisan way.

First, Senator Snowe touched on the bill that she and I have, the MEND legislation, Medicare Enhancement for Needed Drugs. I just want to express my thanks to you for our conversation, because I think we have opened up another way to look at it.

What Senator Snowe and I have wanted to do, is use marketplace forces to contain the cost of prescription drugs, in effect, like

Weyerhauser, a big timber company, would, or a health plan, or anybody else. You have opened up the door to us on that and I appreciate the chance to discuss that with you.

Let me, if I might, ask about this Medicaid issue in a different way, because, as you know, we have tried in Oregon—you worked with John Kitzhauber—to really use waivers in a humanitarian kind of fashion. We said, let us get necessary benefits to people. Let us make sure it improves their quality of life and is medically effective.

The concern is that, if we have block grants of any form with that kind of rigid cap, that that would make it harder for some of these kinds of creative waivers that really do help people.

Can you tell us that you will just oppose the block grant concept as it relates to Medicaid? I think if we have that assurance, we are off to the races in terms of a bipartisan effort to really come up with the flexibility that you and others want. But it would be very helpful if you could tell us if the block grant concept, as it relates to Medicaid, is off the table.

Mr. LEAVITT. Senator, I know of no block grant proposal that would come to you.

Senator WYDEN. That is certainly what I wanted to hear. I think, for colleagues, that really opens up the door now to look at flexibility in a creative kind of way, and I appreciate that.

The second area I wanted to get your reaction to is, I am excited about your interest in health care technology. A lot of us—Senator Smith and I—have many constituents who care about it.

But as I think you know, David Brailer's office, the office has largely been de-funded. I mean, they have lost a lot of the money that they need. I would like to see us go forward with bipartisan work in the health technology area.

Can you tell us that that will be a priority for us to once again get bipartisan support for that office, get them the dollars they need so we can build on some of the innovative work that is being done?

Mr. LEAVITT. I had not been announced as a nominee very many days before I sought Dr. Brailer out. That is an area of interest, and I had read about his work. I have had meetings with him because I believe in the vision that efficiency can be created in our society through technology in health care.

It must happen because we are simply seeing such expansive growth in health care costs, that I believe that they begin to threaten our economic competitiveness as a Nation.

I believe the day will soon come when a doctor can leave an examination of a patient and fill out a prescription on his or her PDA and have it transmitted wirelessly to a pharmacy of the patient's choosing, and have it being filled before the patient leaves the parking lot of the physician's office, and that that prescription can be billed to their insurance company in the same transaction, and their electronic health record updated, and the patient be well-served by that whole thing. That is efficiency.

That begins to meet the vision that I believe we are talking about as opposed to the moment when we all go to the doctor, we wait, we get a prescription, a handwritten prescription we may or may not be able to read, we take it to the pharmacy, we wait. That

is an inefficient system and does not serve the American people well.

We can improve it, and I look forward to finding ways to go through what is a very complex transition as a society that we are engaged in right now.

This is not just happening in health care. It is happening in banking, in finance, in manufacturing, and in virtually every aspect of American society. You and I share an interest in that and I look forward to more conversations and ways to move that forward to more efficiency.

Senator WYDEN. My time is up. I just think that, on a bipartisan basis, we have got to make sure that Dr. Brailer has some resources. I was troubled by the fact that, after all the talk, frankly, by both political parties, to a great extent, that office has been defunded. Perhaps we can get into those issues a little more on the second round. Thank you, Mr. Chairman.

The CHAIRMAN. Now, Mrs. Lincoln. Senator Lincoln, then Senators Bunning, Crapo, and Lott.

Senator LINCOLN. Thank you, Mr. Chairman. Happy New Year to you.

The CHAIRMAN. Happy New Year to you, too. Especially since you do not have any amendments in your hands. [Laughter.]

Senator LINCOLN. Not today. [Laughter.]

I, too, would like to join the committee in welcoming you, Governor. We are glad you are here. We look forward to working with you. We have many, many questions to tackle and many things that we can do together, and we are looking forward to that.

I would also like to welcome the new members of the committee, Senator Wyden, Senator Schumer, and Senator Crapo. Senator Crapo and I have tagged along together in many places. We started in the House together, went to Energy and Commerce together, came over to the Senate together, Agriculture together, and now in Finance. So, I look forward to working with all of them.

I also want to thank you for the time that you have taken to come around and visit with many of us. We do have a lot of questions. I will submit as many of my questions for the record as I can.

[The questions appear in the appendix.]

Senator LINCOLN. I do want to associate myself with Senator Bingaman's comments about Medicaid and its ability to manage the costs that it has. I know, time and again, I have heard your analogy of Medicaid as being a very, I guess your term is rich, I guess, or a rich plan compared to others.

I would just hope that, again, we make sure that we look at what is being compared in terms of maybe, perhaps, apples to oranges, when we realize the tremendous impact that the aging community out there has on the Medicaid dollars.

I know in Arkansas, we have some statistics that really point that out. Medicaid spends about $2,000-plus a year on beneficiaries that are 20 years and younger, but for beneficiaries that are over the age of 65, Medicaid spends almost $11,000 a year.

So, when you look at the amount of money that we are investing in our aging population and the tremendous impact that long-term care has on Medicaid, it is clearly a critical issue to making sure that we provide quality of care for our aging parents and grand-

parents, which we want to do, but making sure that we can keep that program going. So, I hope that we will be very honest and focused on the differences that are there.

You have had many innovative ideas in your waivers, and as a governor you have looked at those objectively. You have said the element of trust is important, and I concur with you wholeheartedly that trust is a critical part of what all of us have to do as public servants.

I hope and trust that you will share with us not only the good things that you learned as governor in the waivers and the programs that you were so innovative with, but I also hope that you will share with us the downfalls, the things that did not work and what we can do to change that.

A couple of questions that I have on some most recent things. As you may know, the MEDPAC Commission has recommended cutting Medicare hospital payments in 2006. Those of us who do represent rural States—and we have talked an awful lot about the rural issues—have some great concerns, as do others.

I guess it is surprising, considering the evidence, that hospital margins under Medicare have declined in recent years to an expected average of negative margins in 2005. The MEDPAC also shows that Medicare has over-paid managed care plans in Medicare.

We subsidize those managed care plans in the Medicare reform piece to a tremendous amount. For States like ours that do not have any Medicare+Choice or managed Medicare products, we feel a little left out on that enormous spending of money.

They have shown that Medicare payments to the Medicare+Choice plans average 107 percent of the cost to cover similar beneficiaries in traditional Medicare. I think that is important.

I guess my question would be, do you support the cuts to the hospitals, and do you think that there is any way we could look at a more fair, and probably a more fiscally responsible, way to cut back on over-payments to managed care plans as opposed to cutting some of our hospitals that are operating, really, at negative margins?

Mr. LEAVITT. Senator, I have only read press accounts of the newest report. As I indicated earlier, it is clear to me that when you are splitting up dollars, it requires our best statesmanship and a lot of patience. I have been in those discussions before, both at the Federal and State level. I pledge to you that I will do my best to be a productive force in the discussion.

I wish I could report to you that I had the magic wand that could make the difficulty of these go away. I must also say, I have been involved in these cost discussions among hospitals, academic health centers, for example, and trying to figure out where the costs are within those.

To say they are confusing is an understatement. To say they are complex is accurate, but also seems underwhelming as an adjective. I will do my best to be part of this commentary.

Senator LINCOLN. Well, I know you do not have a magic wand, but I do know that you will have a lot to say. Certainly, your word and your input will have a lot to do in how we most efficiently use those dollars.

One other thing is the automatic enrollment of the MSP population in the drug benefit. In its proposed regulation, I know CMS decided to randomly enroll the dual eligibles into the drug plan if they do not choose one.

While CMS has, on the other hand, deemed participants in the Medicare savings programs—and my staff always tells me, never use the QMBs and the SLMBs, but those are the MSP folks that are eligible for that low-income subsidy, it has not decided whether to randomly enroll them in the drug plan if they do not choose one.

I would just say that we have really, really desperately worked with CMS to encourage them. These low-income individuals who get a subsidy through Medicare for their deductibles and their premiums on Medicare are highly in need of being enrolled in those drug plans.

We encouraged CMS to do so in the drug card. They did not, or reluctantly waited until the middle of October to get these people. We are seeing a very disproportionate share; less than a quarter of those that are eligible in our State are enrolled.

The numbers that we have been asking for since June we had not gotten until today, unfortunately, State by State. That kind of information is enormously important for us to be able to ask the right questions and to help you in coming up with the kind of answers that are going to make these programs efficient and effective.

But I would ask you to seriously consider the automatic enrollment of those MSPs in the drug program. We tried to get it into the drug card, not just because we want to make sure that these low-income seniors have a program. That $600 would have meant a tremendous amount to that disproportionate share of low-income seniors that did not get it this year.

I just hope we will not miss that opportunity to provide these seniors, not just because they deserve it and it is a quality of life that we should be helping to provide to them, but it also is enormously important in their confidence in what we can do. As we all know, seniors can be reluctant if they are not confident and trusting in what we need to do. So, I encourage you to do that as well.

Mr. LEAVITT. Thank you.

The CHAIRMAN. Thank you, Senator.

Now the next person is Senator Bunning.

Senator BUNNING. Thank you, Mr. Chairman.

Welcome, Governor.

Mr. LEAVITT. Thank you.

Senator BUNNING. Utah and Kentucky have similar problems. We are both kind of rural States, except for a major area like Salt Lake City and like Louisville. We are facing some of our most pressing challenges in providing health care in rural areas.

As Secretary, what areas will you focus on in respect to rural health care?

Mr. LEAVITT. Senator, a surprising outcome to me of our SCHIP effort was that 50 percent of our enrollees came from rural Utah, and only 14 percent of our population exists there. That surprised me, but it also taught me that that is an important tool in serving rural communities.

I have also come to understand how valuable community health centers can be in rural areas, not just metropolitan areas. I have

come to appreciate the importance of being able to have providers, nurses, physicians, and others who are targeted in those areas who are prepared to serve them.

I have come to have the bias that the best people to serve there are people who live there, who grew up there, and who want to go back there. I would cite those as three examples.

Senator BUNNING. In regards to the SCHIP program, we have had an unusual problem in accessing that to our children. In other words, the people in Kentucky have not enrolled in the numbers we expected. We have had a very similar experience, but not nearly as bad, with the Medicaid prescription drug program.

What kind of stimulants can you look for if my SCHIP program in Kentucky is not at 50 percent, or not at 15 percent, or not at 20 percent? What suggestions do you, as Secretary of Health and Human Services, see in making that more available and more accessible to those people?

Mr. LEAVITT. My experience will only reflect that of one governor who went through the experience.

Senator BUNNING. That is fine.

Mr. LEAVITT. But I think we did it successfully, and I would offer the following. Another surprise to me. We were able to enroll nearly half of our total enrollment population, which exceeded our capacity, on-line.

Senator BUNNING. On-line? That is a problem in Kentucky, though.

Mr. LEAVITT. Well, it surprised me that it would not be a problem in our State. People did not believe that those we were trying to reach would have access to the technology, but in reality, they do. We integrated our enrollment search with our schools.

We worked very hard to use it as a tool available to those in our Human Services. It was strictly a function of finding them. I know the President feels strongly about allocating resources to States who will devote themselves to finding those who have needs. They are there.

As I indicated, we did it a little different way in that we created our own plan, as opposed to adopting Medicaid. We were able to increase coverage by a factor of one-third. We covered one-third more children and we have more who would like to be on it than we have the capacity to serve, but they are anxious to continue to expand it.

Senator BUNNING. Well, I think the school is obviously the best tool. Then, following up as you did through the school programs and accessing on-line would be a very good way to get to the nonparticipants.

Mr. LEAVITT. I might also add that a big part of our success was going into clinics and asking, particularly in the primary care or community health area. Our system was set up so, when they came in looking for care, if they did not have coverage, we could give it to them and provide the care on the spot.

Senator BUNNING. Obesity. We read a lot about it. This country seems to be obsessed with it. It is a problem in this country. What do you think Health and Human Services' role should be in combatting obesity?

Mr. LEAVITT. I believe the work that the Department has undertaken under Secretary Thompson's leadership has been exemplary. I think the fact that we are calling people's attention to it and its enormous role in terms of factors of diabetes and heart disease.

I believe it is symptomatic of what I hope the Agency can be, or at least what I would aspire to make the Agency, that is, to open an era of health prevention, not simply treat. We have picked the low-hanging fruit in this country, I believe, on treatment.

The real opportunity for gain is in prevention and obesity plays out in so many leverage points that it is a worthy campaign and one that I intend to continue if I am confirmed, and one that I believe will pay big dividends.

Senator BUNNING. Thank you. My time has expired. I want to also submit to you some questions on steroids and other types of things that seem to have worked their way into our society in various methods. I will submit them in writing for answers.

Mr. LEAVITT. I will be intrigued to receive them. Thank you.

[The questions appear in the appendix.]

Senator LOTT. Senator Crapo?

Senator CRAPO. Thank you very much, Senator Lott.

Governor, I also want to join with those who commend you, and commit to you our support for your nomination and confirmation.

As you know, when we visited we talked about an issue of great importance to me, and that is chronic obstructive pulmonary disease, or COPD. To raise awareness of COPD, I have actually joined with some others and formed a Congressional COPD Caucus, which my colleague, Senator Lincoln, is the co-chairman of here in the Senate.

One important statistic that I think you will come to know very well, is that the annual per capital expenditures for Medicare beneficiaries with COPD is two and a half times higher than those without COPD.

What is more is that, while the death rates from heart disease, stroke, and other cardiovascular disease have been falling dramatically over the last 30 years as a result of our efforts to try to defeat these diseases, the death rates for COPD are continuing to rise. In fact, it is the only major disease now that we are not starting to see a way to get a handle on.

The question I have for you is, have you given some thought as to how HHS can help in slowing this trend and in dealing with COPD, and how can we expand the prevention and awareness of this disease, which is the fourth leading cause of death in the United States?

Mr. LEAVITT. Well, Senator, I will say that your campaign has already been effective with me. I was not conscious, actually, of the ailment by that name. But I thought we had a fascinating conversation in your office.

As I looked at the cause, I said, to Senator Lincoln, to Senator Crapo, you are approaching me in my potential role as Secretary of HHS. But this is really an environmental issue as well because this is about what happens when particulate matter from ambient air begins to inculcate itself into the lungs.

Senator CRAPO. That is right.

Mr. LEAVITT. We are on the verge in this country, under the President's direction, of implementing the Clean Air Interstate Rule, or the President's Clear Skies, which would be a 70 percent reduction in pollution from power plants.

We have also recently implemented the Clean Diesel rule, which will basically dramatically reduce, by some 90-some-odd percent, the pollutants that are coming from diesel fuel. Those tiny black particles that are about the size of one-thirtieth of a human hair inculcate themselves in the lung, and that is what causes, in large measure, COPD.

I would suggest that that will be a giant leap forward in being able to deal with it. I think, also, as a good example, Senator Bunning, of the kind of things we can do in terms of prevention to reduce medical costs and to make this system more efficient. This kind of action and being able to prevent ailments will pay far greater dividends than our efforts to heal them more efficiently.

Senator CRAPO. You make me hope that you can continue to have a major influence at the EPA as well. If we can get HHS and the EPA focused on COPD, then we will make a lot of progress.

Mr. LEAVITT. We ought to make the President's Clear Skies initiative a very good COPD campaign.

Senator CRAPO. We will do that.

Another question that I wanted to ask you, is that the President has been focused very aggressively on rural health care. In that context, he has made a very strong commitment to an investment in community health centers. Could you discuss that and the role that you believe HHS will play in that effort?

Mr. LEAVITT. Well, I am not familiar directly with the initiatives of the Department. I hope to become, because I share the commitment that you have expressed about the need for access to all of our citizens.

I know that access to primary, high-quality care in rural communities is a vital part of their economic vibrance, and for years, as governor in developing the infrastructure necessary for vibrant rural economies, health care, higher education, public education were all basics. So, I will look forward to learning more about the initiative you have spoken of. I am not able to add to the conversation yet, but I hope to be.

Senator CRAPO. All right.

Then, just lastly, I appreciated your interchange with Senator Wyden with regard to health information technologies and efficiencies. I would just like to alert you, I serve as the co-chair here in the Senator on the Steering Committee on Tele-Health and would like to work closely with you and the Department on initiatives to make sure that we take maximum advantage of our ability to expand access to health care and improve the quality of health care through tele-medicine.

Mr. LEAVITT. These conversations do nothing but whet my appetite and heighten my anticipation. These are issues I like, enjoy, and have had some interrelationship with, and I look forward to being part of that.

Senator CRAPO. Thank you.

The CHAIRMAN. Senator Lott?

Senator LOTT. Thank you very much, Mr. Chairman. First, Mr. Chairman, I ask consent that my prepared statement be made a part of the record.

The CHAIRMAN. It will be made a part of the record.

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

Senator LOTT. And I want to thank you for moving aggressively to have this hearing and the cooperation from the Democratic members of the committee, and the agreement that hopefully we could get a vote this afternoon, but as soon as is physically possible when we can get the requisite numbers here.

To you, Governor Leavitt, congratulations and commiserations. [Laughter.] And to your family, your wife, your children, thank you for being willing to make this sacrifice. It is that, but it is certainly a worthy one and one that is needed, and we do appreciate it.

You must really want to serve to be governor of a State, then to be Administrator at EPA, and now to be Secretary of HHS. I am proud of you, but I want to talk to you a little bit about why you would want to do all these things.

But, seriously, it is a huge undertaking, a very important one, and I think you are the right man for the job. I am glad that you were available and the President had the wisdom to select you and nominate you for this position. I believe you certainly will get an early, and probably unanimous, confirmation. Having been a governor and having been head of EPA, to be able to achieve that, is miraculous, actually.

I have worked with you as a governor during the 1990s when we were working on a lot of innovative programs. I have always enjoyed the way you thought outside the box, your aggressiveness in trying to get things done. You are an action-oriented individual, and that is what you need as a governor in this position. So, I thank you for what you have already done.

What you did with Medicaid in your own State, getting 25,000 more Utahns on this system, and the way you did it. I believe you got the first waiver of its kind from the Bush Administration of the Health Insurance Flexibility Initiative, and that made a difference.

You set an example of what can be done if you take a look at how you can serve the people that really need it the most, and sometimes that means making some changes.

One of the things you said, I want to add a little bit to. You said "provide care to the largest number of people possible." That is not our goal, I do not believe, as a government. It is to provide care to the largest number of people who need it. There is a distinct difference in that.

Mr. LEAVITT. I accept that.

Senator LOTT. We do not want to give it to everybody we can afford to. Maybe they do not need it. But we need to make sure that those who need it have it in the right way, it is affordable, accessible, and all those other things.

So, I worry a little bit sometimes that we keep trying to push that envelope to make it available to more and more and more people when we are not necessarily helping the people that need it the most in the ways that they need it. I mean, the fact that you expanded a provision in dental was innovative at the time, I think.

I spoke to our own governor of Mississippi, Haley Barbour, a gentleman you know and have worked with in the past, today. He said to just please say to you, continue that flexibility in the SCHIP program that you have been talking about.

I understand maybe CMS has made some decisions about how funds that are maybe not able to be used can be used by other States who have, perhaps, a greater need. I hope that that is accurate information and that you will support and push for that. I remember, you helped us work on welfare reform, which has not only reduced the rolls, but has allowed us to have ways to help people.

It was never about cutting people off, it was about giving people a bridge to a better education, child care, self-help, and opportunity. There are some miraculous stories that you and Governor Tommy Thompson did at HHS when he was Secretary, and before that when he was in Wisconsin.

So, I have my prepared statement in the record, and I will not go through a long dissertation lauding you for your service. You have a real challenge before you.

I was going to ask a question about the obesity program. I have my pedometer right here. Tommy Thompson pushed it very aggressively. He was also able to do a show-and-tell. He was able to show a before-and-after when he actually lost weight. I do not think there is much you can do in that regard.

Mr. LEAVITT. I have got my own campaign going, Senator.

Senator LOTT. All right. Good. Good.

But, again, it is very serious. It is a serious health problem in America. People that are obese, extremely overweight, they are destined for all kinds of health problems. I have family members and friends who are having to deal with that, so I do hope we will give it the serious consideration and effort that it deserves.

In my waning time, let me just ask you a little bit more. In our efforts and initiatives we have undertaken to extend health insurance to low-income citizens, in particular, through Medicare waivers, the covered-at-work program, I think, which you used, and the SCHIP program, can you give us a little more information of how you think we can build on what you have done and make this program work better, how we can be helpful?

Because we in the Congress have at some times been an impediment. We have not been willing to loosen up and give the flexibility that could be more helpful to governors as they wrestle with these problems.

Mr. LEAVITT. Senator, if there is a principle I would advocate on the question you have raised, it would be, national standards but neighborhood solutions. We do need to establish what our National aspirations are, but they are best met by turning over to local communities the flexibility they need to meet those aspirations. Let me say that, with respect to your suggestion on the way we express our aspiration, I accept that.

Lastly, you asked about my state of mind in the context of doing this. May I say that my time in politics has taught me that public service is dependent on a steady supply of people who do not know what they are getting themselves into. [Laughter.]

Senator LOTT. I think you qualify. [Laughter.] Thank you, Mr. Chairman.

The CHAIRMAN. All right. I have had a request, at least from one member, for questions. Do you want to start a second round of questions?

Senator BAUCUS. Do you have questions?

The CHAIRMAN. No. If I do, I will do them some other time.

Senator Baucus, then Senator Rockefeller, in that order then. You will come after Senator Rockefeller.

Senator ROCKEFELLER. She should come before me, Mr. Chairman.

The CHAIRMAN. All right.

But Senator Baucus, first.

Senator BAUCUS. I will defer to the Senator from Maine.

Senator SNOWE. No, that is fine.

The CHAIRMAN. We have five members here. All right. We will just do a second round in the order.

Senator LOTT. Do we anticipate a vote, Mr. Chairman?

The CHAIRMAN. I think it is going to be very, very difficult, considering the weather outside, based on the discussions that I have had with staff, that we will be able to have a quorum this afternoon for a vote, but we will wait until the last minute to make that decision.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Leavitt, I would just like to have a little discussion with you about the Section 1115 waiver authority, if you would, please.

The theory, clearly, is to allow States to initiate demonstrations, which I think is a great idea. I am sure you agree. I think it is important to note, though, according to the Department, that $21.5 billion in Federal Medicaid waivers are governed by the 1115 waiver agreements rather than under current Medicaid law.

That is a big chunk, $21 billion worth of policies set by waivers which may or may not be in conformance with the statute. Just to put that in a little perspective, this is more than 10 percent of the Federal Medicare spending for the year.

It is also more than the entire discretionary budget for 7 of 15 departments in government. For example, Agriculture, which is $21 billion, Justice, which is $19 billion, Labor, $12 billion, Treasury, $11 billion. That is, the spending under waivers is much greater than 7 of the 15 departments' budgets in our Federal Government.

As you know, this committee has expressed concern about waiver authority. Many of us believe that it has been used to side-step the law. That is, the authority has been used to go beyond what is contemplated under Medicaid and beyond using the waiver program to experiment, demonstration projects, and so forth.

As I said in my opening statement, the GAO studied this issue and they agree. They agree that the administration has gone too far. The administration has not lived up to the law. They have broken the law by going too far, some of it with respect to budget neutrality, some of it gets to the point of dollars, particularly under CHIP programs, going to adults, not to children under some of these waivers.

Also, the process itself has been sort of a black box. It is hard to know what is being waived and why. There is not much trans-

parency here, no guidelines. Other States are not sure who is on first, et cetera.

I would like you to talk about that a little bit and ask you your view on these 1115 waivers, whether, and the degree to which, you will increase transparency so there is some general uniformity and some understanding of good public policy so States, members of Congress, and the general public can know what the rules are. And so we know the rules are not just changed midstream, and whether you will refuse to grant waivers that violate the fundamental aspects of Medicaid, that is, entitlement status, comprehensive benefits for children, and protection of poor people against prohibitive cost sharing. Under some of these waivers, cost sharing has been so prohibitive and there are so few hospital stays allowed, that, in effect, it violates the intent of the Medicaid statute.

Mr. LEAVITT. Senator, let me express that I believe the 1115 waivers are a positive thing, generally, as a tool. They must be done within the law. They must be done in a transparent way. I do not believe they should be used as a means of being able to implement policy generally. It should be used to innovate or to find a specific solution to a problem that is unique to a State.

I do believe there is something to be learned about why there has been so much pressure for waivers. It is primarily because the law as it exists does not provide adequate flexibility for those who are managing what I referred to as neighborhood strategies inherently.

I believe we could mitigate quite substantially the need for waivers if we were to build in the flexibilities into the law within the parameters that the Congress was prepared to extend. That would, I think, begin to take some of the pressure off.

Senator BAUCUS. Well, I agree. If there are pressures building that require changes, the solution should be not to break the law, but to change the law.

Mr. LEAVITT. We should never set out to break the law, and we would not.

Senator BAUCUS. According to GAO—which may be wrong, but most people put a lot of faith in GAO, it is nonpartisan—they said the administration has not been following the law.

If these pressures are there, as you say they are, to what degree is the administration going to come forth with proposed changes to the Medicaid law so that we can accommodate some of those pressures? Can you give me a sense of that?

Mr. LEAVITT. I do not have a sense of that. But I can tell you that I am anxious to work with the members of this committee, and with the Congress generally, to find ways to provide a more efficient atmosphere for Medicaid. It is a big number that we are moving toward, $5 trillion.

Senator BAUCUS. Right. Could you give me a little better sense of what you mean by "transparency"? It may mean different things to different people. What does it mean to you?

Mr. LEAVITT. Well, it means to me that the cards are on the table and people know what you have done and why you did it.

Senator BAUCUS. You, meaning who? Is that Congress?

Mr. LEAVITT. No.

Senator BAUCUS. Is the State involved? Is the Secretary involved? Who is "you"?

Mr. LEAVITT. I was referring to me as a first party.

Senator BAUCUS. Oh. All right. Who is the second party?

Mr. LEAVITT. Well, I am sure people would appreciate Congress acting in the same way. I have no reason to believe they have not.

Senator BAUCUS. I hope we have, too. But, again, we have asked for guidelines. Members of this committee, members not on this committee, have asked for guidelines, and we do not get very far. That is an understatement. We do not get anything. So what I am asking you, is that your definition of transparency or not?

Mr. LEAVITT. I like to operate and manage by principles. I like to be able to look at a problem and say, we are going to see a number of different examples of this problem. Let us establish a set of principles that will guide our efforts to create a sense of consistency.

Senator BAUCUS. No, no. And I appreciate that. But, again, I am asking you, are these principles going to include transparency in the sense that there are rules, there are guidelines that are public, that people are afforded an opportunity to comment on, so that States and the country know what the rule of the road is with respect to waivers, when they are granted, when they are not, and under what circumstances, rather than this black box, ad hoc process that we have experienced.

Mr. LEAVITT. What you have described makes sense to me. I have to confess, I do not know the construct of what is there now. So could we agree, in principle, that that is what needs to occur? There needs to be a consistency about the way we act. I will do my best to find ways to express that, whether it is by rule or by statute, that provides a method of transparency.

Senator BAUCUS. Consistent and open to the public, that is what I mean by transparent. Your policy can be consistent internally. But I am talking about consistent externally.

Mr. LEAVITT. Those are both the transparency in the way you have defined it, and a well-informed citizenry is a——

Senator BAUCUS. Because it is just good government.

Mr. LEAVITT. I agree with you.

Senator BAUCUS. We avoid so many problems otherwise.

Mr. LEAVITT. I am working hard to get to a place of agreement with you, Senator.

Senator BAUCUS. Good. I am working on it, too. [Laughter.] I also urge you, and I know you believe this anyway—my time has expired—is to make that argument very strongly and effectively within the government, that is, the White House and others that may have a contrary view.

In my experience these last 4 years, the White House will have a contrary view. So you are going to have to be very smart and creative within the administration to accomplish good, effective public policy in a lot of areas.

I do not have time to go over the whole long list, but we are a little bit, I will not say jaded, but we are a little bit cynical. Not cynical. We are a little skeptical of some of this. I want to work with you, and we will work with you. I am just encouraging you, be smart, be tough.

Mr. LEAVITT. I think we have done it. We have found agreement.

Senator BAUCUS. All right. Good. Thank you.

The CHAIRMAN. Senator Hatch has follow-up questions, then Rockefeller, then Snowe.

Senator HATCH. Just one. I will not be long, Mr. Chairman.

Governor Leavitt, you were governor of Utah when Utah hosted the 2002 Winter Olympics. The 2002 Winter Olympics was the first international event to take place after the September 11 terrorist attacks, and, I might add, the anthrax contamination of the U.S. Capitol complex.

As a result of your leadership and others', Utah was well-prepared for the 2002 Winter Olympics, which I thought were the greatest Winter Olympics, ever.

How will your experiences from hosting the 2002 Olympics shape your approach to bio-terrorism and for bio-terrorism preparedness for the United States?

Mr. LEAVITT. Senator, I can best answer that question by reflecting on an event that occurred, I believe, the third or fourth day of the Olympics. I was at the figure skating event when I got a call from the Command Center.

Governor, they said, we need you to come. We have detected anthrax in a sensor at the Salt Lake International Airport. Those, of course, were alarming words to me and I began to move as rapidly as I could toward the Command Center.

As I moved, my mind began to work. It was about 6:30 at night. I knew that the Salt Lake International Airport would be, as one of the major airline hubs, full of airplanes landing, filling with people again, and taking off to other cities.

I remembered quite clearly that some weeks before that we had found a large population of workers who had not been properly vetted and were not there legally, and I began to see a sort of sinister plot in my mind unfold, that someone had, in the context of terrorism, released a white, powdery substance into the ventilation system, and that one of our monitors had picked it up, and it was being done as a part of terrorist activity during the Games.

I spent about 3 hours at a laboratory waiting for a more delineating test. During the course of that, I saw exercised the proper protocols necessary to begin asking the questions of what could occur in a widespread attack of that sort.

Who would we call? Who would be in charge? Would we have the capacity to deliver the medications necessary in the timeframes required? Who would be the first responders? Would we have the information systems available to track those who had been on airplanes? All of those questions began to come to me.

Three hours later, I was relieved to find that it was a false read at the airport. We had placed everyone on alert. We had the decision to make as to whether or not to close the airport and turn the nature of the Olympic Games into something far different than they were at that moment. We made the right decision, but it was a rather live-fire exercise for me to understand the depth of how serious such a problem could be.

If I am confirmed, I will have responsibility, under the Presidential Homeland Security Directive, for bio-terrorism. It is a subject that I take very seriously. I believe the Department has made substantial progress in its readiness and preparation.

The Congress has responded by making appropriations that have been disseminated among the States. It is a subject that I would take with real seriousness and make a high priority.

Senator HATCH. I know you would. I think it is important for the American people to hear what you have to say about that. That is why I took the time to ask the question.

I am not going to ask any more questions, Mr. Chairman. I just hope we can confirm Governor Leavitt as soon as we possibly can.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you very much.

Governor, however long we have gone, just remember, Condi Rice, 9½ hours yesterday. [Laughter.] And it probably is still going.

Mr. LEAVITT. I am trying to decide, if I keep my answers short, if more people will show up, or if I get long, people will come back. So, maybe you can help me with some advice on that.

Senator ROCKEFELLER. The secret to it is, give long answers.

Mr. LEAVITT. I will do my best, then.

Senator ROCKEFELLER. Then that precludes questions from coming, you see. Then members get a little annoyed and they leave.

Mr. LEAVITT. Now, that is an incentive for a short interaction then, Senator, and I will do my best.

Senator BAUCUS. That may be your view, Senator. I want long answers.

Senator ROCKEFELLER. I just want to ask two questions. I will ask them both. I will ask them separately, obviously, but at the same time.

This, again, is back to SCHIP. Senator Bunning, that was started in 1997, and it has been an enormous success. But Senator John Chafee and I worked very, very hard on this committee to try and get Medicaid to do that, because of the questions you heard from Jim Bunning and you have heard from others, that every State had different methods.

I mean, we started organizing committees, our governor at that time. Committees did not work. It took us, really, 4 years to get going. It is not easy to do. People say, well, maybe they just do not care. That is not true, because parents fundamentally care about their children. In Appalachia, I like to think that is very true. The idea of home computers is a good one, but most of our folks who would be eligible for that program would not have that.

I think Senator Bunning was probably referring to eastern Kentucky, where most of his problems are. I do not think there would be many there, so they would have to go to a public library to take advantage of the e-rate, which Olympia Snowe and others helped start and which has been a big boon.

Now, there is a billion dollars left over, $1.07 billion, from 2002. That is a lot of money. The decision was made simply to reauthorize SCHIP. But the $1.07 billion is still there and there are States that need that.

You have the sole discretion that remains pending, available, and you have the discretion to be able to make, still, that $1 billion, slightly above that, available to States on whatever criteria that you would select.

I would strongly encourage you to do that. One billion dollars is a lot of money, but a billion dollars in getting children health care is enormously important. I really think it is worth doing.

People say, well, we keep reauthorizing. Well, TANF went out a couple of years ago and we cannot get that reauthorized. It is a hard thing to get done. It seems to me, with that discretion, you could make an enormous difference. So, I urge that, respectfully.

Second, on the question of dual eligibles, which I will just simply, as has been mentioned by Blanche Lincoln and others, that being obviously folks who are of Medicare age, but poor enough that they also qualified for Medicaid. The amazing thing is, there is almost 6.5 million of those folks in this country, about 38,000 in my State.

Now, we are going to have the question of the transition from the Medicaid program to the Part D aspect in the prescription drug program under the new system. The deal sort of says that there is going to be a 6-week transition period. Now, this does not seem to be a very big thing, but it is to me. I think it was MEDPAC that came out this year saying it ought to be 6 months, and they are right.

The reason is, to get the data shifted, to get the patients—who, after all, many are in long-term care facilities, et cetera—familiar with this, as well as to get the prescription transfers correct at the pharmacies, and all of that which is part of the data sharing, you know that cannot be done in 6 weeks.

I do not know why 6 weeks was stuck in there. This is not a matter of, is this going to up the cost of anything. It is just a question of stretching out the transition period to make sure that it is done effectively for this $6.4 million. I would ask your serious consideration of that, sir.

Mr. LEAVITT. Let me comment on SCHIP. I read today that Secretary Thompson, exercising an authority that I am not certain of its origin, has reordered the reallocation of nearly $700 million on SCHIP. So, it is possible. I do not know how to reconcile that with the $1.1 billion, but nevertheless, some action has been taken on it.

Senator ROCKEFELLER. All right.

Mr. LEAVITT. On the second point on the dual eligibles, I have had enough comment on this as I have moved around that it has fueled my interest. What I have discovered is, I still do not know why it was 6 weeks, but it is 6 weeks. The capacity for the Department to change it is not statutorily allowed.

So what they are doing, is concluding to make every effort to get as many during that 6 weeks, and then to make certain that a decision is made on all of them, and then liberally interpreting the capacity to go back and make changes during ensuing weeks to make certain that the right decision was made for each.

Senator ROCKEFELLER. Well, if you are correct that it is in the law, then I stand corrected and then what you are suggesting is a very good idea. Do what you can now.

Mr. LEAVITT. That is the best information I have.

Senator ROCKEFELLER. Yes. Yes. And you are sensitive to the problem, so I am satisfied. Thank you.

The CHAIRMAN. Senator Snowe?

Senator SNOWE. Thank you.

Just several follow-up questions regarding some dimensions of Medicaid. I appreciate what you had to say in response to capping Medicaid as an entitlement and protecting the mandatory populations, which I think obviously is crucial. There has been, as you know, considerable speculation about the possibilities of block granting Medicaid.

I think in either instance, in capping it or block granting it, we cannot mistake it for flexibility, innovation, or even waivers. It is one thing to receive the money, but it is quite another to cap what is available to the States and shifting those costs.

Frankly, it is an indeterminate number of people who might be in need depending on the economy, depending on the need, the level of uninsured, which seems to be growing by the day to now 45 million, which obviously exacerbates the problems with the Medicaid program.

So, I hope that we do not see any proposals in that direction, frankly. I know there has been a lot of discussion about it in the media and the speculation. All I want to say is, I think it would be a mistake to go down that road, frankly. It would not only shift the cost to the States, I think it clearly would undermine support in those services for the neediest populations in this country, without question.

I should also say, in talking to the governor of my State, one of the issues that has surfaced regarding the Federal matching rate under Medicaid is that they use a 3-year look-back. So, for example, between 1998 and 2000 is used as a basis for determining the Federal matching rate. In 2003, for example, the economy was far different than it was in the year 2000.

So I would like to be able to update that Federal matching rate, along with the use of demographics. Again, income is one determination, but demographics are not included in that formula. For example, an aging population. We have one of the fastest growing aging populations in the country. The needs of the disabled is another demographic.

So I would hope that we would be able to have some discussions regarding the ability to change that matching formula. In receiving this letter from the governor recently, who has gone through an experience because we have seen, actually, a decline in the matching rate, even though Maine still has one of the highest, because of the disproportionate number of elderly in our State.

But on the other hand, it was used on the basis of a 3-year period between 1998 through 2000, when obviously our economies were going, as he said, at a much greater rate than they were, obviously, in 2003. In the last few years, we have lost 20,000 manufacturing jobs.

So, I am going to look at this issue regarding the Federal matching rate to see if there is anything more fairly reflective of some of the issues that do, I think, have an impact on States' needs and on these populations specifically.

Second, I will be also sending you a question regarding disproportionate share. As you know, that is the reimbursement to hospitals that have a disproportionate number of Medicare- and Medicaid-eligible individuals.

Some of my hospitals in Maine have had a specific problem recently with the CMS interpretation based on a fiscal intermediary that made the wrong decision regarding whether or not what they were doing, their practices, were reimbursable. This was back in the 1990s.

Now they have decided to pursue seeking reimbursement of close to $30 million from these hospitals. CMS, at one point, thought they would not demand, and now they are reopening the case. I think the point is, here, there needs to be some consistency.

We already recognize that in the prescription drug law that was passed, because it included making sure that hospitals were not required to make payments based on erroneous guidelines and dictates by CMS or fiscal intermediaries. Many hospitals were excluded from having to make those payments, but unfortunately, a lot of hospitals in Maine have not.

So, I really do think that there has to be some consistency in the interpretation of these statutes, because hospitals, in good faith, rely on the consultation and decisions made by the fiscal intermediary, and that, of course, is CMS.

It is being reviewed now, but I do think that this cannot continue to be a problem, because it ultimately results in millions of dollars. Hospitals ought to be able to rely, one way or the other, on whether or not they are allowed certain reimbursements and certain expenditures.

Mr. LEAVITT. I can see why looking back retroactively in the way that you have reflected would be a problem. Not knowing any of the specifics on the matters that you reference, I will just acknowledge what you have said as being true.

Senator SNOWE. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. All right. Now we go to Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Governor, one of the biggest portions of the prescription drug bill, of course, was the billions and billions of dollars that have been earmarked for employers, to keep employers from dropping coverage.

There is great concern I think at this point either that money will not be fully utilized in an effort to find savings or that the administration is in some way going to give short shrift to that part of the bill. I would like to hear your thoughts on how you are going to approach it.

I would be the first to acknowledge there are plenty of reasons employers have dropped coverage, but we want to make sure that the prescription drug bill does not provide another reason for that. I would like to hear your thoughts on that.

Mr. LEAVITT. I would like to respond to your question, Senator, by raising the horizon a little bit and commenting on the transformational need of detaching health care and employment, generally. This is a policy issue because it is so closely tied to employment.

I believe the 21st century view ultimately will be looking for ways in which we can empower American consumers who are well-informed, who own their own health information, who have the ability to access, and that our policies will move us toward that

kind of portability. The problem that you ultimately comment on, I think, is symptomatic of that.

I am not able to, frankly, add a lot to the conversation on the prescription drug bill because I am not familiar enough with the provisions to know what the incentives and disincentives are. I will become intimately familiar as I am confirmed, but today I am afraid that is the most I can offer.

Senator WYDEN. Well, I would just hope that, as we look at the transformational exercise—and I happen to think that there is a lot to be said for making individuals personally responsible for their health care—that we realize that this is a population with a lot of folks who are frail, who are in a position, frankly, in a lot of instances, who find it hard to navigate in the marketplace.

I would just offer up that if we blow, if we muff the way in which this transition is made, more employers drop coverage, we have more older people falling between the cracks, that will hinder your effort to bring about the transformation.

The second point, is the press in the last few days has been reporting that the National Institutes of Health is going to reduce substantially a proposal to make research that the taxpayers have funded available to the country.

Now, I am sure you are just starting to get into this, but I would find it helpful if you could just tell us about your commitment to making sure that the public does get access to this information, because these reports in the last couple of days that come from sources within the Department are pretty troubling.

Mr. LEAVITT. I know very little about the specifics of this issue, but I can just tell you, in principle, that I believe research that is made available by government funding ought to add to the knowledge of an informed public generally and ought to be readily and easily available.

Senator WYDEN. I appreciate that. Let us try to get it down to that short turn-around time, the 6 months, because otherwise the taxpayer pays twice. The taxpayer pays, first, when their tax dollars go for the research, and then they have to shell out more to a scientific publisher. Those publishers fought the Department, there is no question about that. I appreciate your answer.

Two housekeeping matters, if I could, very briefly, Mr. Chairman. The governor of our State, Ted Kulengowski, believes, after he read the re-importation report on pharmaceuticals, that he has a proposal that would address the Department's concerns.

He has had trouble getting a meeting with the Department. If you could just reach out to Governor Ted Kulengowski and make sure that you and your people talk with him, I would appreciate that.

Mr. LEAVITT. Thank you. So noted.

Senator WYDEN. The last point I wanted to mention is really a thank you. I think I told you that Senator Hatch and I have worked for 3 years now on what we think is a transformational proposal in health care called the Health Care That Works for All Americans Act.

The Department has been extremely supportive of this, Secretary Thompson, in particular, his staff. The appointments to the Citi-

zens Health Care Working Group are going to get named by the General Accountability Office at the end of February.

I think this provides an opportunity for the Congress, on a bipartisan basis, to have the discussion about how to create a system that works for everybody, and a very different one, and it is one that Senator Hatch and I have put more than 3 years into.

I want to thank the Department for their support, and also to get it on your radar, as we talked about briefly, for the days ahead.

Mr. LEAVITT. I will look forward to that discussion.

Senator WYDEN. All right.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Governor, I would just like to qualify from one of Senator Wyden's earlier questions. I know in your previous positions you have supported block grants. Your answer to his question, I am not sure if I should interpret that as meaning that you no longer support block grants, or you continue to support block grants in Medicaid.

Mr. LEAVITT. My position has always been that mandatory populations which form up the basis of the Medicaid program as a foundation should remain mandatory, and that optional populations should remain optional.

Senator LINCOLN. So you are only talking about block granting the optional? Of course, we know that two-thirds is really optional out of Medicaid.

Mr. LEAVITT. Senator, the tension we have always felt on these is putting States in a position where it was all or nothing. As a governor, you were faced with not having any capacity to use available resources to reach the maximum number of people. That has always been the tension.

The difficulty has been that, if they are simply optional, yes or no, and we have no capacity to move in between, then States are forced into places where they make decisions they regret they have to make.

Senator LINCOLN. So is your support of block grants really more for the flexibility?

Mr. LEAVITT. Well, my support——

Senator LINCOLN. If we offered you flexibility with per capita caps, is that something that is of more interest to you than it used to be?

Mr. LEAVITT. We are looking back now over a period of a long time, and there were many different proposals, some of which were referred to as block grants, some of them were not, some were thought of as caps, others were not.

The best way for me to respond to your question is to simply give you, as straightforward as I can, my philosophy.

I believe Medicaid does need to have a foundation of mandatory populations and mandatory coverages, and that States need to have the flexibility to build on that according to their own ingenuity, and that they need to have the maximum level of flexibility to reach the largest number of people possible with a benefit plan that approximates that which they believe in their State they can, in fact, afford, and we ought to be their partner so long as they do

not fall below the basic foundation pieces of mandatory populations and mandatory benefits.

Senator LINCOLN. All right. Thank you.

Also, just going back to TANF, we have reauthorized that for 3 years. We have had eight extensions. The administration has frozen child care funding, I guess, for the last few years. The cost of child care has grown tremendously.

I do not know that I am the only one, but I am one of the few in this room that, when the snow came down, I had to worry about where my children were going to be when extended day at school was canceled, which it was. So, I think the issue of child care for our working families in this country is enormous.

What are you going to do to address that? I mean, the issue of the frozen funding for child care, whether or not we are going to move forward on some of those issues and really look at what it reflects for working families.

Mr. LEAVITT. I suspect the most important expression I can make to you is that you understand my belief that it is unreasonable for us to be working to have a single mother or father who is caring for children and have an expectation that they will spend their full time out of the home and not have availability of reasonable cost, safe child care. That has been evident to me as we have moved through the whole welfare reform process.

Senator LINCOLN. I am glad to hear that, because when we talk about additional work hours and more requirements, and yet we do not talk about the increased need of funding, I know that it has certainly increased the wait list in our State over the past 3 years in terms of a need out there for our working families.

Mr. LEAVITT. It would likely be important for me then to complete my thoughts on this, because one of the great successes that I believe we have accomplished as a Nation over the last 5 or 6 years now has been a dramatic reduction in the amount of the caseload on a State-wide basis. In my own case, we have gone from about 20,000 families down to as low as 7,000.

Senator LINCOLN. And those are good numbers. The key is, we realize we are now left with the more difficult, those that have two or three or more of the barriers there that exist, whether it be transportation, child care, and all of the other. So, I hope we will not miss that.

The last thing I want to get in before my time expires is extending the penalty period. Forty million Medicare beneficiaries, their premium penalties will apply. There will be penalties to their premiums after May 15 of 2006 if they fail to sign up for a drug plan.

Unfortunately, with the disappointingly low enrollment in these drug discount cards, which only 14 percent have enrolled, do you think the deadline should be extended? We have extended it for military families going into Medicare, but only temporarily.

Mr. LEAVITT. I do not know if the statutory authority exists to do that. What I do know, is that we are moving into a dramatic new phase of Medicare. I am guessing that some of these dilemmas were faced with Part A and Part B, and that we ought to do what we can and what we need to do to make certain that we ultimately work our way through this transition.

I indicated earlier that it is not going to be without flaw, it will not be without lesson. We will not fail. We will succeed and we will do all we can. I met with Senator Murray earlier today and we had a conversation about the August recess for members of Congress and the importance of being able to have answers for members of Congress.

It occurs to me that one of the ways we can do this is to partner up between the administration and members of Congress as they go back into their districts so that we can utilize the contact that you will be having with your constituents. I would like very much to work with you and other members of the Congress to find ways in which we can deploy jointly to inform them.

Senator LINCOLN. That is all fine and good, but I would say that the state is rapidly coming upon us. If we know what the enrollment rate has been on these cards and the effort that has been put forth, we only have a short time. This is a premium penalty that will go into perpetuity if it is the same as the current Medicare premium penalty that exists.

Mr. LEAVITT. I will make inquiry of that. I am not very well-informed as to the penalties, but I will try to become better informed.

Senator LINCOLN. Well, it is a reality for a lot of people out there, and this can be very dangerous.

The other thing, Mr. Chairman, is I would like to say that I want to associate myself with the issues of information technology. Technology is vital to the efficiency that medicine can have out there, but I would remind you that it is costly.

In rural areas, those costs do not just get taken care of. We have some new and innovative ideas. We are looking at how we can help rural areas and others afford that, and I hope you will work with us.

Mr. LEAVITT. Thank you, Senator.

Senator LINCOLN. Thank you.

The CHAIRMAN. I have one question, and that will be my last. I think Senator Baucus has a few questions he wants to ask, then we will wind it up.

I would like to address the issue of Congressional oversight. Year after year, Congress gives the executive branch more authority. Even so, Congress does not conduct enough oversight, especially nonpartisan oversight, of the executive branch. The Finance Committee has responsibility over your Department. I take that responsibility very seriously.

Over the last year, I have been questioning the Food & Drug Administration about its reluctance to make public certain information about risks associated with pharmaceutical drugs on the market.

I am also holding Medicare officials accountable as they work to implement a massive new prescription drug benefit. Five years ago, I kept the heat on the Agency to finally enforce the laws Congress had passed in regard to protecting nursing home residents.

Over the years, I have dug into problems in other agencies as well. For example, I fought alongside a whistle-blower named Dr. Fred Whitehurst in the mid-1990s to bring about reforms needed to ensure the integrity of the FBI Crime Lab.

I also worked with another whistle-blower who made legitimate accusations about problems in the FBI's translation section, which is so important to the United States' campaign against terrorism. The thing is, no matter who is in charge, the bureaucracy seems to resist scrutiny and the tough questions that come with it.

Too often, government officials think their own agency is an end unto itself. The people's government is the last place that that kind of attitude should be allowed to fester.

That is why I will continue conducting Congressional oversight. I am willing to dedicate the time and resources to asking questions, interviewing employees, and reviewing documents to get answers. I am not going to give up.

During your service as head of this Department that touches the lives of so many, I would like to have your constant cooperation. So my question is very simple: will I receive that consistent cooperation, Governor, while you are Secretary of HHS?

Mr. LEAVITT. Senator, I acknowledge the oversight role played by the Congress, and I will do my best to be a cooperative partner in being able to provide information.

The CHAIRMAN. Thank you very much.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Leavitt, as you well know, a lot of Americans—this is one of the wonderful parts about our country—really do not like the Federal Government intruding into their personal lives.

I am sure that is true in Utah. In fact, I can think of a couple of areas in Utah where that is probably true. It is also true in Montana. There are a lot of people I work for who believe that very firmly, very strongly.

One of the areas that concerns a lot of Montanans is the question of marriage promotion and domestic violence. A lot of people are concerned when they hear the Federal Government is thinking about promoting marriage. Is that not a personal decision, they ask?

What role does the Federal Government play, what interest do they have, and is it right to have issues that "promote marriage"? Without digressing, particularly in this modern time, I am not raising the issue of who is allowed to get married.

But, nevertheless, I would just like to ask your views about that and how far you want to go there, and particularly from the perspective of domestic violence.

There was a survey in Oklahoma recently that showed that 47 percent of divorced women who ended up on TANF had suffered from domestic violence. That is almost half. If we are going to have some kind of marriage promotion, the real question is, what does that mean, what is it? And what about safeguards for women?

Your answer to some of my written questions about this, your written answer, basically says that unhealthy, abusive, and sometimes violent relationships form and can get worse, in part, because of a lack of understanding by partners about how they should act and what they should expect from each other.

Well, there is a lot of truth in that, but that is not always the case. It is my understanding that domestic violence is not so much the result of a lack of understanding, but it is about power, some-

body exercises power over the other spouse, usually, but not always, the male over the female.

I think we have to be extremely careful going down this road so we do not cause problems or unintended consequences by, frankly, encouraging more battered women to stay with an abusive spouse. I would just like your thoughts on that issue.

You also mentioned in your prepared response that States should involve local domestic violence experts in the development of service plans they propose for funding. What do you mean by that? Who are these local domestic violence experts?

The real concern on the part of a lot of people is that, if you start pushing people into marriage or keeping people in a marriage that should not continue, you are going to have a lot more violence instead of less.

The CHAIRMAN. Before you answer that, could I also tell Senator Baucus that this is very much an issue that he raises and we probably have not satisfied you yet on that in our legislation.

Senator BAUCUS. I am just asking questions.

The CHAIRMAN. No. No. But I want to tell you my intent of trying to work on that, because it is a problem.

Senator BAUCUS. All right.

The CHAIRMAN. I do not think the White House even wants that to happen, and we want to work with you to see if we can address that adequately. At least, that is our intent.

Senator BAUCUS. This is about the only issue we discuss publicly because it is the only issue where we have a little bit of a disagreement on handling it.

Mr. LEAVITT. You are doing well. Keep it up.

The CHAIRMAN. And I am not talking to Senator Baucus now to disagree with him. I am just talking to him about, we do need to address this. I want you to address his question, too, but I think we have this bill coming up, and he and I have to work together to get this worked out. I think, hopefully, we can do it.

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. Yes.

Mr. LEAVITT. Senator, I have been present in many, many situations with victims of domestic violence in shelters that we have created across our State, when I was governor, for that purpose.

I have had occasion to sit with them directly and listen to what are horrifying tales of difficulty and disruption. I am also aware that it is a growing trend in our society that cannot be tolerated. Likewise, I would like to acknowledge——

Senator BAUCUS. Let me just interject here. It stunned me. We all have these kind of work days where we work at home at some job. One day I was riding along with the police department in Billings, Montana. It was a Friday evening, near midnight or later. I was stunned at the number of calls we responded to that were domestic violence cases. More than half were domestic violence cases.

Mr. LEAVITT. And they are not always just spousal. They are often involving children, which adds another dimension to this very difficult problem.

Likewise, I would like to acknowledge my belief that society is well served by strong marriages and that society has an interest,

not in making the personal decisions about whether to marry or whether or not to be married, but to help those who are to have strong marriages. Children are healthier.

In our welfare circumstances, we find that if the families can be preserved voluntarily because of assistance we have given, that is a positive thing.

My wife and I did sponsor a commission called the Marriage Commission. It was one of the first in America. Our purpose was simply to make known the important social value that exists there and the value that exists to children and to society generally in the long term.

Senator BAUCUS. I appreciate that. I think everybody does. But if you could, with a little more specificity, address the question of forcing people to either marry or stay in a marriage where there is domestic violence.

Mr. LEAVITT. I know of no public policy that I have been involved in or that I would support that would disrupt the choices, the individual, personal choices of people. I do not know of any State where that would be the case either.

Senator BAUCUS. I appreciate that. Thank you very much.

I would like to move now a bit to the so-called fall-back plans. You are from a rural State, I am from a rural State. As you well know, when we wrote the Medicare bill a lot of us from rural States were very concerned that there will not be adequate drug coverage in rural States compared with large States.

The earlier versions of the bill said there have to be at least two so-called PDPs, or private plans. Then we said one could be a managed care plan. But then the question arose, what about those parts of the country where there just is not a sufficient population base to persuade a private plan to come in and want to serve?

So, what do we do about that? In the law, as you know, we said that HHS/CMS has to come up with fall-back plans, where the government basically contracts with a single plan to provide the benefits.

Well, it is my understanding that the administration has not done very much to develop the fall-back plans. In fact, to the degree they have, the standards are much tougher, which, in effect, may mean that people in rural areas are going to have inferior drug service under the bill.

I think I proposed a written question to you along these lines. But if you could just give us your thoughts about that, please.

Mr. LEAVITT. First of all, I am aware in the bill of the requirement of a vibrant market being in every region of the country. We will meet that obligation. I hope that we will need to use fall-back plans in the fewest possible number of areas, but where we need to, we will. We will assure that there is a market like the one described in the bill in every area. I am committed to that, and I know the President is.

Senator BAUCUS. And do you know the degree to which fall-back plans have been developed? After all, this goes into effect pretty soon, about a year from now.

Mr. LEAVITT. I do not know with any certainty the degree to which those are being contemplated. I can assure you that part of

the success of this, I believe, is going to be assuring that we meet that.

Senator BAUCUS. When you get confirmed, could you look at that, please?

Mr. LEAVITT. I would be delighted to do that and report back to you.

Senator BAUCUS. And just let me know how it is coming along. It is really concerning. Montana is a State of over 145,000 square miles, a lot of folks. Sometimes it is cold in the winter and it is hard to travel. We just want to be assured that we are treated equally.

Mr. LEAVITT. Yes.

Senator BAUCUS. And make sure that the regulations of the fallbacks are not more onerous or stringent compared with the other PDPs.

Mr. LEAVITT. As you are aware, the rule that will define the requirements for the potential carriers is in the final stages of preparation. I have not seen that rule, therefore, the nature of the task is still somewhat unknown to me, but the priority of it is not.

Senator BAUCUS. Mr. Leavitt, let me ask you about specialty hospitals. I am concerned about specialty hospitals. It would have been interesting for you, being such a public policy person, to have been in the room, in the conference, first of all on the drug benefit bill, but, second, the time we spent on specialty hospitals and the pitched battle between two conferees, one in the House and one in the Senate, over specialty hospitals.

One said we must give specialty hospitals special privilege. The other disagreed, because he believes they are skimming. They are taking the best patients, the ones who pay more. And these facilities do not have to provide emergency care or other services that most community hospitals must provide.

As you know, MEDPAC recently came out with a recommendation to extend the moratorium against building new specialty hospitals until 2007. What is the administration's view on the MEDPAC recommendation?

Mr. LEAVITT. That is actually a subject I am not able to add a lot to. I am aware of the issue, generally. It is another one of those that I need to bring myself up to speed on. I have not been involved as governor, nor in my previous public policy discussions, directly with specialty hospitals. I will look for conversations to understand them, but I do not know now.

Senator BAUCUS. Whatever it is worth, when I am home I quiz doctors about this. I ask them what they think. I must tell you, I am surprised at the degree to which doctors think it is a bad idea, these specialty hospitals, because they are getting such a better deal compared with other doctors, other hospitals.

These doctors say it is just not fair. Here I am at this hospital, I am a good doctor. I have talked to doctors that explain to me the number of procedures they have and they are bringing revenue to the hospital. They love their job.

But they think it is also their responsibility to be part of an organization that is providing full service, a full-service hospital. They resent it—and I agree with them—that some of their colleagues leave, go form a specialty hospital in which they have an equity in-

terest—an orthopedic specialty hospital, or a cardiology specialty hospital, or whatever it might be—and they do not have to provide the other services.

MEDPAC, as I said, recommended extending the moratorium at least until 2007, I assume for some of the same reasons I suggested. I urge you, when you are looking at this issue, to keep in mind, it is just not fair, in my view.

Now, the other side of the coin is, there are specialty hospitals that provide special service, and so on, and so forth. But I think most people can get good care without having to go to a specialty hospital.

Mr. LEAVITT. When I read the MEDPAC report, I will take some care to learn that. It is an issue that is now more heightened in my mind than it was before, but I am afraid I cannot respond to you now.

Senator BAUCUS. While we are on MEDPAC, have you had a chance to look at their recommendations with respect to Medicare reimbursement?

Mr. LEAVITT. I have just read news reports of the most recent one.

Senator BAUCUS. As you know, that is going to be a big-time issue here.

Mr. LEAVITT. There is a long list, I am afraid, with those.

Senator BAUCUS. I know it is long. It is.

The CHAIRMAN. What he said is an issue, because on June 30 that moratorium runs out. So, that is something that Congress, if we decide to keep the moratorium, will have to be dealing with this year. You said you didn't understand it.

I think the simple way to respond to it is, the *Wall Street Journal* point of view, that you ought to have these specialty hospitals because it gives the marketplace an opportunity to work, and people have more choice.

But the rural point of view is that it is going to skim off doctors and income from hospitals that are forced to take anybody, and with the loss of the expertise and the revenue, it is going to be very difficult to deliver quality care in rural America. Is that fair to say?

Senator BAUCUS. Yes. That is a large part of it. It is not just rural.

The CHAIRMAN. I suppose I always think in terms of rural because we have been getting screwed for the last 20 years on these formulas.

Senator BAUCUS. But you are changing that.

The CHAIRMAN. Well, we have.

Senator BAUCUS. Yes.

The CHAIRMAN. But it could be a problem, particularly in the poor parts of urban America as well.

Senator BAUCUS. Just a couple of quick questions here. One, is on the cancer reimbursement. I am sure you know the issue. What I hear, and I do not think this is self-serving, is that the reimbursement—the new rules—with respect to rural doctors are more onerous than they are for non-rural cancer practitioners. That is, the reimbursement for the drugs versus the administrative practices reimbursement. I would just like you to please look into that.

You will not believe, I get tons of e-mails. That is a little strong. I get an awful lot of e-mails from Montana oncologists on this very point. Just like in Utah, we all trust each other in Montana. So I figure that these folks, they are not putting one over on me. I know these people. They are honest, good, decent folks. There must be a kernel of truth in what they are saying.

Mr. LEAVITT. Thank you. I will.

Senator BAUCUS. Second, I do not know if this is discussed a lot, but I think this is really key for the future. We have a huge opportunity, and also a responsibility, in my view, to develop very aggressive new programs to address quality of care in America.

The health care industry is so inefficient. There is room for so much more improvement in this area. There is so much paperwork. Even those with IT systems do not talk to each other. It is a mess.

We waste so much time. I know that the administration's budget talks about dollars for IT, but it is spread out over much too long a period of time, in my view.

I would urge you to go back and look at the IT budget and see if there is a way to address giving that a real kick to get it moving, because right now the talk is maybe about 10 years. We cannot wait that long.

Also, for the sake of competitiveness. We are spending so much, as I mentioned earlier in my opening statement, on health care costs in this country that need not be spent and have nothing to do with health care, and in fact diminish the quality of health care because of the inefficiencies.

It gets to the question of just what hospitals and providers can do locally. I was talking to one fellow who told me they have brought death by infection down to zero—zero—just by instituting different steps in the hospital, particularly infection control procedures to reduce infections caused by catheters and so forth. They have done it with all kinds of little things, for example, making sure people are properly gloved.

And visually. They have taken a page out of Toyota's notebook, because Toyota has learned that much of quality control is visual. For example, they put stripes around dangerous areas so people see it.

They put index cards with stripes so they know when the gloves inventory is low. Once you have old gloves, they do not work. That is why doctors do not use them, because they do not have the right gloves when they walk into a room.

A lot of this can start at the top, but a lot of it has to be done at local hospitals. This could help address the Medicaid and Medicare cost problems. Really, it is just axiomatic.

Mr. LEAVITT. I see it as among the, first of all, areas of my greatest interest, and second of all, an area where the Department can have great impact on the overall——

Senator BAUCUS. Huge. Huge.

Mr. LEAVITT [continuing]. Of the overall health——

Senator BAUCUS. And part of it is organizing business. The BRT, the Business Round Table, has a huge interest in this because they have got to get their health costs down.

Mr. LEAVITT. Right.

Senator BAUCUS. You can use them as sort of pilot projects, get them going in some companies. I suggest you get a team of industrial engineers and some CPAs and go, say, 5, 6, 8 months to some hospitals that are doing this, or not doing it, to see how much they can do to get costs down, because the current incentives just do not work that way. They work the wrong way.

When you do that, you are going to find huge potential savings, which will give you clues as to how to begin to work in changing the incentives. You are the guy. You are the man.

Mr. LEAVITT. It is an opportunity that I find great anticipation on.

Senator BAUCUS. I can give you the names of people that I urge you to talk with, with whom I have been speaking. It is clear. We should be reimbursing based on outcomes, quality outcomes, not just on service.

Mr. LEAVITT. Back in my home State, we have one health care system called Inter-Mountain Health Care, which you are probably familiar with. They have some services in Montana. But they have begun to look for the quality quotient in everything they do.

In fact, yesterday, during the hearing, Senator Kennedy showed charts from this hospital organization on how they had been able to reduce infections inside hospitals by being able to modify the treatment regiments.

Senator BAUCUS. And do you know the cost of infections? It is a hugely expensive cost.

Mr. LEAVITT. It is prevention.

Senator BAUCUS. It is prevention.

One last question. That is, the dual eligible transition. I have heard a lot of concerns at home from a lot of folks who fear that they are not going to be able to choose what kind of plan makes sense for them, particularly in areas where there is no managed care. They do not know what automatic enrollment means.

I urge you to get started now to get that thing in place so we do not have to hurry up and catch up at the end of the year when the dual eligible issue is going to otherwise come to a head.

Mr. LEAVITT. I am quite sensitized to this, and have become more today as I have heard Senators comment.

Senator BAUCUS. I will tell you, at home this is a real concern. What are we talking about here? We are talking about vulnerable seniors, older people. They are poorer. They will have a harder time knowing where to go to get a plan, to get their drug plan. Some are disabled, some have mental impairments. This is a group of people that needs some extra help.

Mr. LEAVITT. As you know from our previous conversations, our objective at this point is to make certain that a decision is made in the best possible way, and then use lots of flexibility and many opportunities to try to bring them one at a time to make sure we have made the right decision for them.

Senator BAUCUS. Mr. Chairman, I have no more questions.

Mr. Leavitt, I think you are going to be a great Secretary.

Mr. LEAVITT. Thank you.

Senator BAUCUS. Great.

Mr. LEAVITT. I look forward to working with you, Senator.

Senator BAUCUS. You are going to be a great Secretary.

Mr. LEAVITT. Thank you.

Senator BAUCUS. And I want to thank you, Mr. Chairman, for indulging all of my questions.

The CHAIRMAN. Yes.

Senator Wyden?

Senator WYDEN. Mr. Chairman, I came back because I was under the impression we were going to vote the nominee out. What is your pleasure?

The CHAIRMAN. My pleasure is to adjourn, because we cannot get a quorum. My intention is, in consultation with Senator Baucus, to do this either on the floor or next week when we convene a committee meeting here to do our organization, one or the other, whichever is the quickest that can be done.

Senator WYDEN. Mr. Chairman, you have been very generous to me. I would ask, then, if I could submit a couple of additional questions to the nominee in writing. It is my intention to support the nominee.

The CHAIRMAN. Yes. Thank you very much.

[The questions appear in the appendix.]

The CHAIRMAN. I have said what I need to say for closing. The inability to get a quorum will carry this over until Monday or Tuesday of next week. It is my intention of working very quickly to get your nomination out of committee.

Mr. LEAVITT. Thank you, Senator.

Senator BAUCUS. And mine, too, Mr. Chairman. I think it is very important.

The CHAIRMAN. Yes. Yes. Well, if it can be done sooner, as there was discussion here, we will do it just as soon as we can.

Senator BAUCUS. Right.

Senator HATCH. If we have votes tomorrow, we might be able to hold a quorum.

Mr. LEAVITT. Thank you very much, Senator.

[Whereupon, at 5:25 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. JIM BUNNING

Thank you, Mr. Chairman, for holding this important hearing today.

Today we have before us Governor Michael Leavitt, who has been nominated to be the Secretary of the Department of Health and Human Services. I appreciate the time you have taken to be here today, and I hope we can move your nomination through the Senate quickly.

The secretary of HHS has a tremendous responsibility in running a Federal agency that touches the lives of millions of Americans on an almost daily basis. The secretary is responsible for overseeing the benefits for about 40 million Medicare beneficiaries along with coordinating benefits with States for about 40 million Medicaid beneficiaries.

The secretary also oversees the important research work conducted by the National Institutes of Health, along with running programs ranging from preventing AIDS to establishing community health centers to training nurses. Just as importantly, the secretary of HHS has an important role to play in being ready to respond to a terrorist attack, including overseeing research and coordinating with States and local governments to make sure everyone is prepared.

Governor Leavitt has an impressive background—running the State of Utah for 11 years, serving as chairman of the National Governor's Association, heading up the environmental protection agency and serving as a member of the President's homeland security advisory council.

I look forward to hearing from Governor Leavitt today about how he plans on meeting the challenges facing the Department of Health and Human Services in the coming years. It won't always be an easy job, but being secretary will give you an opportunity to shape the future of health care in this country for years to come.

Thank you.

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Governor Leavitt, welcome. First, I would like to take this opportunity to thank Secretary Thompson for his devoted public service over the past 4 years. During his tenure Secretary Thompson successfully led the Department through the September 11th tragedy and the flu vaccine shortage.

He was also instrumental in passage of the Medicare Modernization Act of 2003 and has successfully completed 200 regulations on time with 27 pending publication, a difficult task that will continue into 2005.

Looking back at these past events and looking forward to the new challenges that await us, it is most fitting that we start the first health care hearing of the 109th Congress with Governor Leavitt's nomination.

During his tenure as governor, he reduced the number of uninsured children through his work on the Children's Health Insurance Program and significantly increased the number of those with health insurance coverage by 400,000. He improved immunization rates by nearly 75 percent and made significant improvements to the child welfare system.

I am certainly not alone in my high estimation of Governor Leavitt. The people of Utah recognized his strong leadership capabilities by re-electing him for three consecutive terms as Governor.

Certainly, big challenges lie ahead for this department, and strong leadership is needed. First and foremost, there are an estimated 45 million Americans who lack basic health coverage.

Each year, the ranks of the uninsured increase. As Secretary, your leadership will be called upon to propose innovative ways that we can help contain costs and increase access to health care. This is surely one of the biggest health care challenges of our time.

The Medicaid program is the key Federal program for providing health care access to low-income individuals and families. It is now the largest Federal health care program in terms of total spending, and it served about 51 million people in 2002. Yet it was originally enacted in 1965, and many have suggested that it has not kept up with today's challenges.

Increasingly, States have been forced to rely upon the 1115 waiver process to manage the program, and these waivers are negotiated with little Congressional oversight.

I look forward to working with Governor Leavitt to ensure that Medicaid is functioning as effectively as it should be.

Since 2003, the GAO has ranked Medicaid among its "high risk" programs. I hope Governor Leavitt is as surprised as I was to learn that CMS allocates only eight full-time employees to Medicaid program integrity. Congress and the Agency need additional oversight of the Medicaid payment error rate. Medicaid dollars lost to fraud, waste, and abuse must be saved and directed to the millions of low-income Americans who need them.

On the issue of SCHIP, $1.1 billion in SCHIP allotments expired last year and were returned to the treasury. In addition, there are anywhere from 4 to 6 million children who are uninsured, despite being eligible for coverage under SCHIP or Medicaid.

And over the next 3 years, a growing number of States, including my State of Iowa, are projected to consume their Federal SCHIP allotments, and when this happens they will lack the Federal funds necessary to provide their current level of SCHIP coverage and benefits.

We need to recapture the $1.1 billion in SCHIP funds, increase our outreach efforts to enroll more children, and we need to revitalize the SCHIP program so that it is on firm financial footing.

Finally, we need to enact improvements to the 1996 welfare reform bill. We have debated this issue now for over 3 years. It is time for action. The numerous short-term extensions are disruptive to the program, and I look forward to working with you, Governor Leavitt, to get a welfare bill sent to the President this year.

The Department also has the important job of implementing the new Medicare prescription drug benefit. Under Dr. McClellan's leadership, the Centers for Medicare and Medicaid Services have accomplished an impressive workload over the last year.

Dr. McClellan and the staff at CMS are to be commended for their long hours, hard work, and dedication. This is a crucial year for the drug benefit, and I look forward to working with you in this area as well.

Medicare still faces significant challenges to be sure. Medicare spending grew by 5.7 percent in 2003, and as spending continues to increase there is a growing need to restrain its growth.

Many have said rising costs in health care can be contained and health care quality improved by paying providers based on their performance and by utilizing health information technology.

The Department has taken significant steps to reduce health care costs and provide better care through chronic care management initiatives and additional preventive benefits, like the initial "Welcome to Medicare" physical and screenings to detect heart disease and diabetes that were added by the Medicare Modernization Act.

The Department also called upon Dr. Brailer, as the National Coordinator for Health Information Technology, to develop, maintain, and oversee a plan focused on the nationwide adoption of health IT in both the public and private sector.

Bringing these initiatives together to reward quality and efficiency while reducing medical errors and duplication will be one of the major undertakings in health care over the next decade, and strong leadership at HHS is needed to help make it happen.

Another issue on which your leadership is needed is the importation of prescription drugs from Canada and other developed nations. American consumers are demanding lower prices on prescription drugs, and I believe that legalizing importation under conditions that ensure safety is the right thing to do.

I look forward to working with my colleagues on both sides of the aisle to craft legislation that will pass Congress and be signed into law by the President.

Finally, I would also be remiss if I did not address an issue that continues to be of great concern. Governor, the frail and the elderly residing in our Nation's nursing homes deserve high quality care. I am confident that I can rely on you to work hand in hand with me to ensure that they receive no less.

Besides these issues, the Department faces other significant challenges. I have always taken the responsibility of conducting oversight of the Executive Branch's operations very seriously, and I have and will continue to do so as Chairman of the Finance Committee.

Government truly is the people's business, and Americans have a right to know what their government is doing and how it spends their money. Transparency in government coupled with aggressive oversight is critically important in helping to make government more transparent, more effective, more efficient and more accountable to taxpayers, program participants, and beneficiaries.

In that regard, I am a firm and ardent supporter of whistleblowers. Historically, whistleblowers have been the key to uncovering waste, fraud and abuse. Unfortunately, whistleblowers are often as welcome as a skunk at a picnic.

As the nominee to be Secretary of the Department, you will be responsible for the Food and Drug Administration, the Centers for Disease Control and Prevention, and the National Institutes of Heath, among others. Unfortunately, a number of serious and potentially life-threatening problems have come to light at these agencies, in large part thanks to whistleblowers.

In particular, the FDA has come under increasing scrutiny on issues of drug safety. Governor Leavitt, it will require your strong leadership to make the FDA more transparent and to restore the public trust. Scientists working in that office are not to be muzzled and overcome by the pressures placed on them by other offices at the FDA. The American people deserve to know their drugs are safe.

A number of individuals have blown the whistle at the FDA. These patriotic Americans are scared that if they tell the truth, they will suffer retaliation at the hands of senior officials.

With that in mind, Governor Leavitt, I want your public assurance that anyone who exposes problems at your Department will have their rights as Federal employees fully respected and will be permitted to speak with this Committee or any member of Congress without fear of reprisal. You understand that I need employees at the Department to hear you because I know that they are listening. I look forward to addressing these problems with you.

It is my hope that the Finance Committee will work closely with Governor Leavitt to address some difficult issues that affect millions of Americans.

Taking a closer look at Medicaid and SCHIP improvements, implementation of the new Medicare drug benefit, importation of prescription drugs, enactment of welfare reform, and the advancement of information technology and quality in health care are just some of the priorities I look forward to addressing with Governor Leavitt and my fellow colleagues.

Let me close by thanking Governor Leavitt for his willingness to serve as Secretary for the Department of Health and Human Services. It is a major commitment that requires personal sacrifices on many levels.

I would also like to thank President Bush in his choice of such a qualified and competent candidate.

Thank you.

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS

Mr. Chairman, I want to add my voice to those of our colleagues welcoming Governor Leavitt before the Senate Finance Committee today. As I told Governor Leavitt when he and I met last week, I intend to vote to confirm the Governor to be the Secretary of the Department of Health and Human Services, but I appreciate this opportunity to raise a few issues particularly important to the Finance Committee. I will also submit a few questions to the Governor for the record.

Governor, in addition to the Finance Committee, I also have the privilege of serving, along with Senator Bingaman and Senator Frist, on the Senate HELP Committee. I believe that taken together, these two committees share jurisdiction over every program at HHS. We are all aware of just how important these programs are to the health and well-being of all Americans—so I am pleased that we are acting quickly on your nomination.

I was glad to read your praise of Tommy Thompson in your opening statement, and I join you in saluting his stewardship of HHS. Although we didn't always see eye-to-eye on every issue, we were able to reach agreement on many matters important to our citizen's health and well-being.

In the area of health policy, I suspect that you and I will have more views in common than we have had in your current position, and I am looking forward to having a much more collaborative working relationship with you. Let me mention a few areas with which I have significant concerns.

As a supporter of the recent Medicare legislation, I was glad to learn of your commitment to those provisions most helpful to rural beneficiaries and providers as well as the provisions guaranteeing the prescription drug benefit. I'm especially concerned that rural States like Vermont and Utah have access to competitive plans so that rural Medicare beneficiaries can benefit from lower, competitive prices.

In a related area, I believe that one of your most noteworthy responsibilities will be as a trustee to the fiduciary solvency of the Medicare trust fund. In that vein, I would urge you to look closely at the ability of the Department to help facilitate the opening of international trade markets for prescription drugs and to reexamine the extent to which direct price negotiation between the Secretary and prescription drug manufacturers could help reduce the expense of drugs to the Medicare and Medicaid programs.

I am also significantly concerned about Medicaid funding and the specter of limits on the Federal obligation to the medically underserved. I know that the governors, including Governor Douglas in Vermont, would like to have greater flexibility in providing Medicaid benefits, and that is something I believe we can work with. But frankly, I am wary of the Administration's proposal to provide States with the flexibility to "expand access" at the same time it is proposing to cap and block-grant the Federal contribution to the States.

Another issue that we need to address in the coming months is welfare reform. You played an important role in the welfare reform of 1996, working in a bipartisan fashion with President Clinton and members of Congress to produce historic legislation. The significant flexibility yielded to the States in that law has yielded largely positive results. The last couple of years, we have been struggling to develop a new welfare authorization, and I am looking forward to working with you to help the States build upon and improve what has been done since 1996.

Welcome back to the debate, Governor, and I look forward to hearing your testimony and your plans for the Department of Health and Human Services.

PREPARED STATEMENT OF HON. MICHAEL O. LEAVITT

Good morning. Mr. Chairman, Senator Baucus, and members of this Committee: Thank you for inviting me to discuss my nomination to be Secretary of Health and Human Services.

I would like to begin by expressing my immense admiration for Tommy Thompson. We have been friends for many years, but my admiration is broader than just friendship. I admired his leadership as governor of Wisconsin. The two of us worked together on many of the issues we will talk about today. He also brought an aggressive agenda to HHS, and his 4 years at the helm have made America healthier and safer.

Consider: Medicare is providing more comprehensive care to more American seniors than ever before. HHS is better prepared than ever to respond to public health emergencies. More children receive immunizations and health care, and fewer use drugs. The Food and Drug Administration is inspecting seven times as much imported food as it did 4 years ago. And, thanks to the leadership of President Bush and Secretary Thompson, the United States leads the struggle against AIDS around the world.

Tommy has earned the affection and respect of the people of HHS, and I pledge to him and to you that, if confirmed, I will build on his legacy.

I have enjoyed every stage in my career, from business, to being governor of Utah, to protecting the environment as Administrator of EPA. Now, President Bush has asked you to confirm me as Secretary of Health and Human Services. I want to thank him for his confidence and thank you for assessing my fitness to serve.

As a prelude to answering your questions, it may be helpful if I tell you what I believe, what issues and opportunities I see confronting our Nation, and how I view the Department of Health and Human Services.

I believe conducting the public's business is a sacred trust. I pledge that I will serve with fidelity and full effort.

I believe collaboration trumps polarization every time and that solutions to complex problems have to transcend political boundaries.

I believe that information technology is challenging old institutions, bridging great distances, and giving people more control over their own lives. To survive, governments will have to be more flexible and more competitive.

I believe market forces are superior to mandates. People do more, and do it faster, when they have an incentive to do the right thing.

I believe we should reward results, not efforts. Our focus should always be the outcomes we are striving to achieve.

I believe that to change a nation, you have to change hearts. And you change hearts through education and example.

I believe government must care for the truly needy and foster self-reliance and personal charity. Helping others is good for the soul. Government can augment this compassion and provide services, but it can never replace the love that makes us help each other.

I expect the Department of Health and Human Services to achieve our Nation's noblest human aspirations for safety, compassion, and trust.

When we gather our families for dinner at night, we rely on HHS to ensure the food we put on the table is safe.

When we are alone at night caring for a sick child, we trust HHS to ensure that the medicine we give her is effective.

Our poor, disabled, and elderly have health insurance because this Nation has made it a priority; another powerful stewardship that has been given to HHS.

The Department of Health and Human Services helps to strengthen marriages and families, protects children, and fights disease. For example, we are often called upon to protect neglected and abused children. But we can never replace the love of a parent.

And if, God forbid, terrorists should ever unleash a biological agent on American soil, we would rely on the dedicated men and women of HHS and the plans they have developed already to stop the disease in its tracks and protect Americans.

We all know that HHS spends nearly one out of every four dollars collected by the Federal government in taxes. I am humbled by the prospect of shouldering that responsibility.

I would like to thank the members of this Committee for the kindness you showed me as I visited your offices. Our conversations have been helpful as I contemplate this task. One of you said, only partly joking, "Why would you want a hard job like that?" There are so many reasons. Let me mention a few, beginning with welfare and Medicaid.

WELFARE REFORM

In the late 1990s, in my role as Chairman of the National Governors Association, I worked closely with Congress and other governors in building the Federal-State partnership we called welfare reform. We can all be proud of this dramatic American success story. We set a tone of compassion for this country by caring for those in need and fostering self-reliance. Now I look forward to working with you to ensure that welfare reform is reauthorized and improved.

MEDICAID

During the same period, Congress worked hard at reforming Medicaid, but ultimately failed. I vowed then that if the opportunity ever arose again, I would seize it. Delivering health care to the needy is important, but Medicaid is flawed and inefficient. We can do better. We can expand access to medical insurance to more people by creating flexibility for our State partners and transforming the way we deliver it.

MEDICARE

When you and your colleagues approved the Medicare Modernization Act, Mr. Chairman, that was a great achievement. And you asked us to implement the Medicare prescription drug benefit on January 1, 2006. This is a great challenge.

I have no illusions about the size of the task. It is immense. But I recognize that the President and the Congress made a solemn commitment to America's seniors. I have the responsibility of delivering on that commitment. Our work will not be without flaw, but we will not fail.

GLOBAL

This Nation's compassion is not limited to America. We live in a prosperous country. And our prosperity is not only a blessing—it's also an obligation. While the world sometimes envies or resents us, it always respects us. And when we do the right thing, others emulate our example.

In international health, one of our Nation's greatest strengths is our considerable convening power—it's our ability to inspire, to set an example, and to call upon the

best knowledge, experience, and resources, from individual experts, private institutions, and government agencies.

I resolve to use this convening power to meet our obligation as human beings to improve health and well-being. We will reach out to reduce suffering, to promote understanding, and to inspire compassionate action.

FDA, NIH, AND CDC BRANDS

HHS is the trustee for a number of our Nation's most treasured brands. A brand is a promise. Over decades, the dedicated scientists and researchers of HHS have earned the public's trust, especially in three brands: FDA, NIH, and CDC. To millions of people, these brands are seals of quality, safety, and best in the world research. If they lost their reputations, they would take years to recover. HHS always needs to keep in mind the ethical implications of its decisions, to ensure that Americans can be proud, not only of the Department's scientific expertise, but also of the moral judgment of its leaders.

At FDA, our goal must be to inform consumers about risks and benefits. Our foundation must be sound science. Our motto must be independence.

At NIH, we must march forward with life-saving research, and always hold the scientists, universities, and laboratories accountable for results.

At CDC, our guiding focus must be disease prevention and control, sharing generously the best health and safety information in the world.

LIABILITY

Most doctors make a sincere effort to do a good job, but medical errors do occur. People who are harmed by medical errors absolutely deserve prompt and fair compensation. Unfortunately, the capricious liability system that prevails in many States helps no one. Senators, I look forward to working with you to pass comprehensive medical liability reform.

TWENTY-FIRST CENTURY HEALTH CARE

Most broadly, Americans deserve the health care of the twenty-first century. We've earned it. That includes modern medical technology. Modern information technology. And modern, consumer-focused delivery systems.

I see a world that is rapidly moving toward personalized medicine. People will own their own health savings, health insurance, and health records.

I see a world in which a doctor can write a prescription on a handheld device and transmit it to the patient's pharmacist, who can start filling it before the patient leaves the doctor's parking lot—and with less chance of error or delay.

I see a world where doctors heal our loved ones when they are sick, but focus more of their energies on keeping them well in the first place.

I see a world where good health care makes America more productive, not less competitive.

And I see a world where premier health research serves the betterment of mankind.

CONCLUSION

Mr. Chairman, I have always had three goals in public service. I followed them as governor of Utah. I've followed them as Administrator of EPA. And I will follow them as Secretary of Health and Human Services.

The first goal is to leave things better than I found them. The second goal is to plant seeds for future generations. And the third goal is to give it all I have.

I promise to work with this committee in a responsive and transparent manner so we can do just that.

Thank you for your attention, Mr. Chairman. I look forward to answering your questions.

The False Claims Act

Will you support the efforts of CMS and the IG as well as qui tam whistleblowers to use the False Claims Act to suppress fraud against Medicare?

Answer:

I intend to support the efforts of CMS and the Office of Inspector General (OIG), as well as qui tam whistleblowers and DOJ, to use the False Claims Act to combat fraud against Medicare and other Federal health care programs. I believe the False Claims Act is a critical tool in the government's fraud-fighting arsenal, and has been successful in reducing fraud against Government health care programs.

Investigating Health Care Fraud

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established a national program to coordinate federal, state, and local law enforcement efforts to prevent, detect, and prosecute health care fraud and abuse in the public and private sectors. HIPAA also established the Health Care Fraud and Abuse Control Program fund (HCFAC) to provide funding to the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) for these efforts. However, other priorities may be diluting federal efforts to prevent, detect, and prosecute health care fraud and abuse. In October 2003, in response to our request for information, the DOJ notified the Finance Committee that since the terrorist attacks of September 11, 2001, the Federal Bureau of Investigation (FBI) had shifted some resources away from activities to address health care fraud in order to support the counterterrorism priority. As a result, we have asked GAO to review FBI's internal controls in place to maintain accountability over HIPAA funding and the extent to which FBI expended those funds on health care fraud investigations.

To what degree has the DOJ-and especially the FBI-been an active and effective partner in working with HHS to prevent, detect, and prosecute health care fraud and abuse?

Answer:

The OIG, which is responsible for investigating health care fraud and abuse at the Department of Health and Human Services, has a long and successful working relationship with DOJ and the FBI. At the grass roots level, the OIG's Office of Investigations (OI) meets on a regular basis with its counterparts in the FBI and the United States Attorneys Offices and share intelligence. The OIG, DOJ, and the FBI also share information and conduct joint investigations to ensure the efficient use of resources. Regional efforts are augmented by regular meetings in Washington between senior level executives to discuss effective and coordinated responses to emerging trends in fraud and abuse. Finally, DOJ sponsors quarterly health care fraud working group meetings that are widely attended by prosecutors, investigators, and staff of this Department.

To what extent does HHS receive information from the FBI that could be used to oversee its use of annual HIPAA funds for health care fraud activities?

Answer:

In preparation for the annual HCFAC report, HHS collaborates with DOJ and the FBI, with each agency providing information about accomplishments resulting from HIPAA funding. This information is available and published on both the OIG and DOJ websites.

What actions do you plan to take to strengthen the partnership with DOJ?

Answer:

I look forward to working as Secretary to maintain and strengthen the Department's relationship with DOJ. This can be done by ensuring that the Department continues to work closely with our colleagues at DOJ and the FBI as described above, including by continued information sharing and collaboration to ensure that dollars are used efficiently and effectively and by continued sharing of programmatic changes that might impact the fight against fraud and abuse.

If HHS had additional funds to address health care fraud and abuse, what activities would be most critical to augment or implement?

Answer:

Health Care Fraud and Abuse Control dollars support a wide range of HHS activities, including Medicare integrity efforts at the Centers for Medicare and Medicaid Services, Office of Inspector General investigations, audits, and prosecutions, and litigation support by the Department's Office of the General Counsel. Such activities include fraud determinations, medical necessity reviews, and auditing providers. Total HCFAC spending in FY 2004 was $1.074 billion (including DOJ/FBI). As you know, the President will soon be presenting his Fiscal Year 2006 Budget proposal. The issue of adequate funding to address health care fraud and abuse is one that I look forward to working with the Congress on as we move forward.

Medicare Power Wheelchairs

In 2003, Medicare and its beneficiaries spent more than $1 billion for power wheelchairs, one of the program's most expensive individual items of medical equipment. Medicare pays about $5,000 for each power wheelchair-not including accessories-making them an attractive target for individuals who would defraud the program and its beneficiaries. In fact, despite efforts to safeguard program funds by the Medicare contractors that process and pay power wheelchair claims, millions of dollars have been spent on claims submitted by suppliers that were intent on defrauding the program. For example, Medicare paid suppliers for power wheelchairs that beneficiaries never received or when less expensive manual wheelchairs were actually delivered.

Prompted by concerns about fraud and abuse in Medicare's power wheelchair benefit, my committee held a hearing on this issue in April 2004. The information presented at that hearing was both startling and informative. For example, the Department of Health and Human Services' Office of Inspector General testified that there was evidence that unscrupulous wheelchair suppliers had gained a foothold in the Medicare program. GAO also testified on weaknesses in how CMS and its contractors had addressed improper Medicare payments for power wheelchairs. Since the hearing, GAO has made several recommendations to guard against improper payments. For example, GAO recommended that CMS develop a process to analyze trends in Medicare spending and develop and implement strategies to address possible improper payments, implement revisions to provide clearer information for power wheelchair claims adjudication, strengthen the standards that suppliers must meet to obtain or retain their Medicare billing privileges, and direct that routine site visits to suppliers be conducted so as not to be predictable in their timing. CMS agreed with GAO's recommendations and, beginning in September 2003, undertook a number of initiatives to curb the abuse of Medicare's power wheelchair benefit. While it is important for CMS to safeguard program funds, it is also important for the agency to focus on ensuring that Medicare is providing power wheelchairs to beneficiaries who need and qualify for them.

What strategy would you take to balance the responsibility to reimburse beneficiaries for needed power wheelchairs with the need to safeguard Medicare funds against fraudulent or abusive billing for power wheelchairs?

Answer:

It will be my goal as Secretary to ensure that there is a balance between getting power wheelchairs to those who need them and protecting against fraud, waste, and abuse. CMS is currently focusing on using a set of clinical and functional data that is evidence-based to better predict who would benefit from a power wheelchair or scooter. CMS also intends to issue a regulation addressing the requirements for ordering mobility equipment. The regulation would, in part, implement provisions of the MMA and would be designed to ensure that Medicare beneficiaries who get mobility devices receive a high-quality and timely evaluation, appropriate device choice and clear guidance in using the device.

Earlier this year CMS announced an initiative to reduce improper payments through the use of enhanced data driven tools now available. Building on its current program integrity efforts, the agency is implementing new steps to analyze program data to detect improper payments and potential areas of fraud and abuse more quickly and accurately. CMS is using these analyses to more effectively educate providers and beneficiaries about ways to prevent and minimize waste, fraud and abuse. CMS also issued a proposed regulation for states to report improper payments for wheelchairs in Medicaid and State Children's Health Insurance Programs.

What steps has CMS taken to improve its analysis of trends in Medicare spending that could indicate improper payments for other items of durable medical equipment?

Answer:

I understand that CMS works closely with our contractors and that they have a data driven system to ensure that Medicare is paying appropriately and to identify potential problem areas. We will continue to focus on ways to identify where fraud is occurring.

Oversight of State Medicaid Program Integrity Activities

The Medicaid program, given its size and scope, is vulnerable to improper payments, including fraudulent or abusive billing and erroneous payments. Although CMS has several initiatives to enhance Medicaid program integrity, the agency has not devoted sufficient resources to overseeing states' Medicaid program integrity efforts. In fact, a recent GAO report concluded that CMS's program oversight was disproportionately small relative to the risk of serious financial loss. While federal Medicaid benefit payments exceed $244 billion each year, the agency allocated just $26,000 and 8 staff nationally to review state program integrity activities in fiscal year 2004.

What would you do to improve weaknesses in federal oversight of Medicaid program integrity?

Answer:

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring the program integrity (PI) of the Medicaid program, as well as the Medicare program and to protect taxpayers and beneficiaries from unscrupulous persons looking to defraud these programs. Over the past several years, the CMS has put in place a number of initiatives and programs designed to enhance and strengthen the overall PI effort. I also understand that CMS has emphasized and taken actions to greatly increase the coordination and integration of Medicare and Medicaid PI efforts. I certainly intend to continue these efforts and will look closely at what further actions may be warranted.

As a former Governor, I am well aware of the fact that states directly administer the Medicaid program and that they are on the front lines of PI efforts and activities. All states have staff, systems, processes, and procedures in place to combat fraud in the Medicaid program. I will certainly look at how CMS may be able to enhance their efforts.

What additional steps would you propose CMS take to support states' efforts to combat Medicaid fraud and abuse?

Answer:

I understand that CMS is in the process of building on its current PI efforts by implementing new steps to analyze program data to detect improper payments and potential areas of fraud and abuse in the Medicare and Medicaid programs more quickly and accurately. CMS will be using these analyses to more effectively educate providers and beneficiaries about ways to prevent and minimize waste, fraud, and abuse. As Secretary I will work with CMS to make sure that combating Medicaid fraud continues to be a priority.

Should CMS play a larger role in preventing and detecting Medicaid improper payments?

Answer:

With the implementation of the Medicare Modernization Act (MMA), CMS now has additional responsibilities requiring increased oversight, including the Medicare-approved drug discount card program, Medicare managed care plans, and ultimately the prescription drug benefit.

I believe that most health care providers want to do the right thing and one of the most important ways to prevent fraud and abuse is to be clear about what the Medicare and Medicaid rules are, and that means education and collaboration with responsible providers.

On August 22, 2004, CMS issued a proposed regulation that implements the Improper Payments Act of 2002, by requiring states to measure improper payments in Medicaid and State Children's Health Insurance Programs (SCHIP) and calculate the error rates based on eligibility, medical necessity, and data processing. The state-specific error rates will be used to calculate a national Medicaid payment error rate. CMS anticipates that state corrective actions will help reduce improper payments in Medicaid in those areas. I'm certain more can be done and as Secretary I will certainly look into this area more closely.

Contracting with Medicare Administrative Contractors

The Centers for Medicare & Medicaid Services (CMS) will face a major management challenge as it implements contracting reform provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA requires CMS to use competitive procedures to replace its current claims administration contractors-intermediaries and carriers-with new Medicare administrative contractors (MAC).

Claims administration contractors play a crucial role in providing service and support to both Medicare beneficiaries and providers. For example, in fiscal year 2003, these contractors processed over 1 billion fee-for-service claims, paid more

than $200 billion for beneficiary health care services, provided claims processing and customer service to about 33 million beneficiaries, and worked with approximately 1.1 million health care providers. Currently, intermediaries primarily review and pay claims from hospitals and other institutional providers covered under Medicare part A, while carriers review and pay part B claims submitted by physicians and other outpatient providers.

Under contracting reform, CMS will be responsible for planning and implementing the transition to MAC contracting, which differs substantially from the current contracting environment. For example, MACs will be responsible for processing claims for both parts A and part B. In addition, while there were previously restrictions on organizations that could be awarded contracts for Medicare claims processing, CMS will be able to enter into contracts with any eligible entity, and full and open competition will be required. Furthermore, while CMS generally paid intermediaries and carriers on a cost reimbursement basis, it will now be tasked with designing performance incentives for MACs to promote quality service and efficiency. To lay the groundwork for the implementation effort, CMS will need to make key decisions, including the number of MACs, the jurisdictions for which they will be responsible, and the specific functions that they will perform. Functions include beneficiary and provider service, adjudication of appeals, provider education and training, and payment safeguards. The MMA required the Secretary of the Department of Health and Human Services (HHS) to submit a plan to Congress by October 1, 2004 on implementing Medicare contracting reform. CMS is permitted to begin competing contracts for MACs on October 1, 2005 and will have until 2011 to initially compete and transition all current Medicare fee-for-service contract workloads to the new authority.

The Medicare contracting reform plan required by the MMA has not yet been submitted to Congress. What approach would help facilitate the plan's submission?

Answer:

Updating Medicare's contracting authority is a significant programmatic reform included in the MMA and an important priority for this Administration. The Administration believes that these reforms will not only bring Medicare contracting in line with standard government contracting procedures, but in doing so, it will allow CMS to contract with the most efficient and responsive entities available, thus improving claims processing services for beneficiaries and providers.

Because these critical reforms will change the fundamental nature of Medicare claims processing contracts, developing an implementation plan requires careful thought and reasoned analysis. As Secretary, I will work to ensure that CMS develops a detailed implementation plan and will hasten the plan's submission to Congress.

Given the delay, how will you ensure that CMS is ready to begin contracting under the new authority?

Answer:

As Secretary, I will work to ensure a smooth transition as Medicare contracts move into the new competitive environment. In fact, I expect that the time and effort taken in preparing the implementation plan will be critical to ensuring the ease with which CMS transitions to this new competitive environment.

What strategy will HHS employ to help ensure that the transition to MAC contracting runs smoothly and that beneficiaries and providers are not adversely affected?

Answer:

Contracting reform offers CMS and the new Medicare Administrative Contractors (MACs) the ability to improve customer service for beneficiaries and providers by integrating Part A and Part B of the Medicare program and facilitating the adoption of modernized information technology. I believe that these kinds of strategies will aid providers and beneficiaries as they navigate their way through this new streamlined system. Of course, key to this effort is ensuring that the needs of beneficiaries and providers are met during the transition to the new contracting environment, and I will work with CMS to ensure that this is the case.

CMS's Program Safeguard Contractors

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), in part, to provide better stewardship of the Medicare program. Until this time, the Centers for Medicare & Medicaid Services (CMS) had traditionally delegated most of the responsibility for safeguarding the Medicare program to the claims administration contractors that assist it with processing and paying claims. With HIPAA's enactment, CMS had, for the first time, the authority to contract with specialized entities, known as program safeguard contractors (PSC), to combat fraud, waste, and abuse.

In 2001, GAO reported that CMS initially experimented with different approaches to utilizing its new PSCs but had not yet developed a long term strategy for effectively managing its new contracting authority. CMS later announced it would gradually shift responsibility for detecting fraud and abuse away from the claims administration contractors to a group of PSCs, known as benefit integrity contractors. These specialized PSCs were expected to perform a variety of vital tasks, such as conducting analysis to support fraud investigations, developing fraud cases, and providing assistance to law enforcement.

How is HHS ensuring that CMS's strategy of concentrating it program integrity efforts in the benefit integrity PSCs is an effective means of identifying potential instances of Medicare fraud and abuse?

Answer:

From an operational perspective, concentrating program integrity efforts with a single set of contractors permits CMS to focus its efforts on combating fraud and abuse. Program Safeguard Contractors (PSCs) have access to a greater range of data, including Part A, Part B, and DMERC claims data, than do claims processing contractors. I understand that this allows the PSCs to perform better, more targeted data analysis and identification of potential fraud. Furthermore, separating the claims processing function from the integrity functions mitigates any conflicts of interest that are inherent when the entity that pays claims is also responsible for checking whether the claim should have been paid. Finally, PSCs perform integrity functions in a FAR contracting environment, which allows CMS and HHS to ensure that performance meets the required standards.

How is CMS evaluating the success of the benefit integrity PSCs in investigating, and referring potential instances of Medicare fraud to law enforcement?

Answer:

CMS conducts regular performance evaluations that include review of referrals made by PSCs to law enforcement, oversight of data analysis performed by the PSCs, and assessment of all facets of a PSC's performance. In addition to reviewing a PSC's performance under the terms of its contract, CMS looks at the actual and estimated savings associated with overpayments identified by PSCs, and the potential value of cases referred to law enforcement, vulnerabilities identified by PSCs, benefit integrity edits developed by PSCs, and denials based on pre-payment medical review performed by PSCs.

CMS's Provider and Beneficiary Help Lines

CMS has established telephone help lines to assist both Medicare providers and beneficiaries get answers to their questions about the program. These help lines are operated by Medicare contractors. In February 2002, GAO reported that CMS needed to improve its communications with providers, whose call may involve questions about how to bill the program correctly. GAO found that 85 percent of the 61 test calls it made to provider help lines with billing or policy-oriented questions resulted in incorrect and incomplete answers. More recently, in June 2004, GAO reported that the situation had further declined with 96 percent of responses to its 300 test calls being incorrect and incomplete. GAO cited several factors, including confusing information and difficulties in retaining call help line staff, which appears to account for the lack of correct and complete answers. GAO also noted CMS's oversight of its contractors was inadequate. GAO recommended that CMS develop a process to triage incoming calls and route them to staff with greater expertise. In addition, GAO said that CMS should provide help line staff with clear and accessible information and enhance its oversight of these contractors. CMS generally agreed with this approach.

CMS's beneficiary help line-1-800-MEDICARE-has also experienced similar difficulties. In December 2004, GAO reported that this help line provided inaccurate answers to 29 percent of the 420 test calls placed. For 10 percent of these calls, GAO could not get an answer at the time the help line was called. GAO also found that the training for help line staff met CMS's requirements, but it was not sufficient to ensure that they are able to answer questions accurately. As a result, GAO recommended ways to improve the 1-800-MEDICARE's training and scripts that help line staff rely on to respond to calls. GAO also urged CMS to implement more specific monitoring of call accuracy. In response to these findings and the wide media coverage of the GAO report, CMS stated that it intended to adjust its training protocol for help line staff. CMS also indicated that would make changes to its monitoring process and analysis of monitoring reports.

What progress has CMS made in implementing GAO's recommendations?

Answer:

Beneficiary Help Lines
CMS continues to look for ways to improve and build upon the already high level of service provided at 1-800-MEDICARE. In that vein, CMS appreciates recommendations that the GAO has provided. The GAO review was a "snapshot" of 420 calls out of the 1.2 million calls received in July 2004 that involved some specific "test" questions asked by GAO reviewers. CMS believes that the findings from these detailed and uncommon questions should not be used to generalize about the performance of CSRs at 1-800-MEDICARE. However, CMS understands that the MMA provisions can be complex to understand and CMS is working harder than ever to train call center staff on how to answer the more complex questions. In order to answer some of these more complex, uncommon questions related to the MMA, the reference staff at each call center have been provided materials to handle these inquiries. When appropriate, these types of updated materials are regularly provided to reference staff. Another example of CMS' efforts to implement the GAO recommendations includes the implementation of additional routing plans that ensure callers are not transferred to a site that is closed.

Provider Help Lines
One of the most important responsibilities of the Centers for Medicare & Medicaid Services (CMS) is to communicate program information to health care providers so that they can bill the Medicare program properly. As Secretary, I will work to ensure that CMS continues to improve its communication efforts.

With regard to the July 2004 report, CMS agreed with the GAO's recommendations and, in September 2004, CMS released instructions to its contractors that will improve the accuracy of responses to calls made to provider help lines. These instructions create a triage system for provider telephone inquiries to ensure that questions are answered by the person with the correct level of expertise. The most complex inquiries will be handled by a new group within the contractor that will have the time to adequately research an issue before responding in writing. The CMS also expanded its provider

education efforts to include training that is tailored to assist smaller providers and reduce the error rate. The CMS has also initiated "Ask-the-Contractor" teleconferences and additional internet offerings to assist providers to bill the Medicare program properly.

What other steps will you take to ensure that CMS follows through on its intended efforts to improve the accuracy of information that Medicare help lines provides to beneficiaries and providers?

Answer:

Beneficiary Help Lines
CMS continually monitors services provided at the call center to ensure that the objective of providing clear and accurate responses is being met and to make service improvements when needed. Callers are surveyed regularly and CSRs are monitored to check if beneficiaries are getting the assistance they need. CMS' focus is not whether the "full script" of information that CSRs have available is being used, but that beneficiaries receive personalized, responsive answers to their questions and are not overloaded with unnecessary information that may be confusing.

CMS will continue the monitoring of call centers, testing scripts and other educational materials to ensure that beneficiaries are provided with the highest quality service and most accurate information possible.

Provider Help Lines
Responding to providers and beneficiaries in a timely and accurate manner is one of the Department's most important responsibilities. The CMS has made significant improvements in the past year and, if confirmed, I will strive to continue these improvements to ensure that the Medicare contractors are able to provide the best customer service to health care providers serving Medicare beneficiaries.

What other steps would you encourage CMS to employ to improve the accuracy of information that it provides to its callers?

Answer:

Beneficiary Help Lines
CMS continues to employ a variety of methods to ensure the accuracy of information to callers. A majority of scripts have been consumer tested in the development of Medicare publications. In addition, CMS holds regular focus groups to identify ways to explain complex concepts, in an easy to understand manner, to beneficiaries for a variety of purposes. It is true that there is not sufficient time to "test" every script as there are occasions where scripts are developed in response to urgent issues which have become "hot topics".

In addition, to ensure beneficiaries are getting what they need and deserve from their call center contacts, CMS took an additional step to verify the quality of service being

provided at the call centers. Specifically, in the past year, an independent, specialized quality evaluation contractor conducted "mystery shopping" calls to determine if CSRs are being "fully responsive" to callers. Employing the services of an independent contractor is a step we could use again in the future as a means to ensure the accuracy of the responses callers receive at CMS' help lines.

Provider Help Lines

CMS receives millions of calls to its provider call centers every quarter. The current overall completion rate of almost 91 percent is the highest it has ever been for the provider call centers. Many CMS contractors are taking innovative approaches to intelligently route incoming calls and improve customer service. As Secretary, I plan to continue in this direction to promote the excellent customer service that CMS is capable of providing.

Oversight of Medicaid Home and Community-Based Services (HCBS) Long-term Care Waivers

The Medicaid program is the primary vehicle states have used to expand the availability of home and community-based long-term care services-as an alternative to institutional settings, such as nursing homes--for low- and moderate- income Americans. The Secretary's authority to waive certain provisions of the Medicaid statute has afforded states considerable flexibility to design and implement a wide range home and community-based programs for physically and cognitively disabled persons whose care needs would otherwise qualify them for costly institutional care. More than 275 state waiver programs currently serve over 700,000 vulnerable Medicaid beneficiaries.

In June 2003, GAO reported that CMS had limited information on states' HCBS quality assurance systems. Available information, however, indicated serious quality-of-care problems such as failure to provide necessary services, weaknesses in plans of care, and inadequate case management. GAO recommended that the Administrator of CMS take several specific steps to ensure that state quality assurance efforts and federal oversight are adequate to protect the health and welfare of waiver beneficiaries. Although CMS acted to develop more detailed criteria for waiver quality assurance systems and to require states to provide more specific information about quality assurance as part of the initial waiver application, concerns remain about the agency's commitment to strengthen federal oversight by allocating sufficient resources and to hold its regional offices accountable for conducting thorough and timely reviews of state waiver programs.

What is your view of the proper balance between flexibility and accountability with respect to Medicaid home and community-based waivers? In other words, what role do you believe the federal government should play in providing guidance for and oversight of states' Medicaid community-based long-term care programs in order to ensure that frail elderly individuals are receiving appropriate care?

Answer:

The home and community-based services waiver program, authorized by section 1915(c) of the Social Security Act, affords states considerable flexibility, within broad federal parameters under the Medicaid program, to develop programs that meet the specific needs of defined populations. I support providing states with this flexibility as long as it is balanced with the requirements in section 1915(c)(2)(a) of the Social Security Act that, "necessary safeguards ... have been taken to protect the health and welfare of individuals provided services under the waiver..." Therefore, it is the responsibility of the Federal government (CMS) to ensure that: 1) state flexibility does not impede upon the State's ability to meet this assurance, and 2) state systems that form a quality framework for state oversight of the waiver program are in place and ensure the protection of individuals' health and welfare.

Will you agree to see to it that CMS follows through on its commitment to strengthen federal oversight and hold states accountable for ensuring and improving the quality of services in these programs?

Answer:

Yes. In fact, I understand that in January 2004, CMS implemented a new process to monitor state oversight of home and community based services (HCBS) waiver programs. This new process holds the state accountable for demonstrating the effectiveness of its waiver monitoring and oversight.

Under the new process, CMS has the responsibility to assess state oversight of each HCBS waiver to determine the adequacy of the states management and oversight of the program, including whether the state meets the waiver assurances.

CMS' new approach will rely on information provided by the states, through on-going dialogue and interaction, in conjunction with their internal self-monitoring activities.

CMS is also in the process of revising the HCBS waiver application. One of the outcomes of the new application will be to incorporate in the application (on the front end) the state's quality management oversight structure. I will ensure that states will be regularly monitored against the program as described in the application.

CMS is also in the process of revising the annual HCBS reporting format so that on an annual basis the state can provide feedback on its quality assurance efforts. Upon confirmation, I will look forward to working with CMS to receive updates on the information the states are reporting.

Nursing Home Quality

Combined Medicare and Medicaid payments to nursing homes for care provided to vulnerable elderly and disabled beneficiaries totaled about $64 billion in 2002, with total federal payments of approximately $45.5 billion. Numerous GAO reports and

testimonies since July 1998 have focused considerable attention on the need to improve the quality of care for the nation's 1.7 million nursing home residents. Significant weaknesses in federal and state nursing home oversight that GAO identified included: (1) periodic state surveys that understated the extent of serious care problems due to procedural weaknesses, (2) considerable state delays in investigating public complaints alleging harm to residents, (3) federal enforcement policies that did not ensure deficiencies were addressed and remained corrected, and (4) federal oversight of state survey activities that was limited in scope and effectiveness.

Beginning in July 1998, CMS announced a series of initiatives to address the weaknesses identified by GAO. GAO reports in 2000 and 2003 noted federal enforcement and oversight improvements but also pointed out critical areas such as survey methodology, complaint investigations, surveyor guidance, and federal oversight surveys where CMS initiatives had still not been implemented. Those reports concluded that sustained efforts were required to realize the potential of the quality initiatives. CMS's own report card on its nursing home initiatives in December 2004 cited progress that had been made but also laid out an "Action Plan for Further Improvement of Nursing Home Quality," thus acknowledging that important work remains to be done.

Do I have your commitment to make the further improvement of nursing home quality, including the completion of CMS initiatives announced several years ago, a priority during your tenure as Secretary of HHS?

Answer:

If confirmed, I intend to work with CMS and Congress to ensure further improvement of nursing home quality.

If so, what specific steps would you envision taking to signal that this is a priority for your tenure?

Answer:
As you know, the Department released its Action Plan for further improvement of nursing home quality on December 22, 2004. This document describes over thirty activities the Department is undertaking to improve nursing home quality in four key areas: (1) consumer awareness and assistance; (2) survey, standards and enforcement processes; (3) quality improvement; and (4) quality approaches through partnerships.

I want to build on the progress already made by CMS. As part of its aggressive action plan for nursing home improvements, CMS is undertaking the following initiatives:

- Strengthen the investigation of complaints from residents, family members, and others by requiring states to use a standard nation-wide complaint tracking system

that will help to better track and analyze complaints, building on increased complaint investigations conducted by CMS or States in nursing homes;
- Improve fire safety by increasing the number of comparative life-safety surveys and issuing a regulation requiring smoke detectors in areas of nursing homes that do not have automatic sprinklers;
- Increase the number of quality measures to assist consumers and providers alike in evaluating nursing home quality.

CMS has also made considerable progress in a number of areas that the GAO has identified as needing improvement. One major accomplishment is the creation of Nursing Home Compare, a consumer tool on our Medicare.gov website. Nursing home compare is the most used portion of the CMS website, with more than 42,000 visits each week.

To address the problem of "yo-yo" compliance – a term used to describe the pattern of on-and-off nursing home compliance, CMS also instituted a policy referred to as "double G". This policy ensures that nursing homes with two successive surveys with findings of "actual harm" (a "G" rating) are subject to immediate enforcement actions rather than being given further opportunity to correct their deficiencies.

CMS has also published a regulation that adds another type of civil money penalty to their enforcement actions – a per-instance CMP which complements the existing per-day CMP and gives us broader enforcement tools to encourage compliance of nursing home requirements.

CMS has implemented a special focus facility (SFF) program to address the problem of poor-performing facilities. In this program, states and CMS selected two facilities per state that will receive an additional standard survey. While this program did show nursing homes in the program showed greater improvement, CMS made a number of changes to the SFF program to make it even more effective. For example, CMS expanded the overall number of special focus facilities by nearly 30% from 104 homes to 135 homes.

CMS implemented state performance standards in FY 2001 to better hold state survey agencies accountable for their performance.

CMS is implementing the criminal background check pilot required by the Medicare Modernization Act. The Department announced in December 2004 that it has selected 7 states to operate pilot programs: Alaska, Idaho, Michigan, Nevada, New Mexico, South Carolina and Wisconsin.

Understatement of Nursing Home Quality Problems

Since 1998, GAO's work on nursing home quality has consistently demonstrated that state surveyors missed or understated the seriousness of care problems that harmed residents-problems such as significant, unexplained weight loss or serious

pressure sores. Most recently, a November 2004 GAO report found that Arkansas state surveyors often failed to cite serious deficiencies for coroner referred cases of suspected neglect of residents while Medicaid fraud investigators found neglect and reached monetary settlements with some of the same nursing homes. GAO identified underlying causes for the understatement of serious care problems including (1) the predictable timing of state survey, which could enable a home so inclined to cover up deficiencies, and (2) a survey methodology that does not rely on an adequate sample of residents for determining potential problems and their prevalence.

On several occasions, GAO has reported that CMS's response to its 1998 recommendation to decrease the predictability of surveys was inadequate. For example, GAO reported in 2003 that the timing of 34 percent of surveys nationally could still have been predicted by nursing homes. Although CMS is rolling out during 2005 a survey scheduling system to help states vary survey dates, the agency's December 2004 "Action Plan for Further Improvement of Nursing Home Quality" noted that use of this system was optional. CMS's 2004 action plan also noted that the agency would begin evaluating a new survey methodology, under development since 1998, during late 2005. The final evaluation report from testing in three pilot states is due in the fall of 2006.

Given the significant percentage of predictable nursing home surveys, what additional actions does CMS plan to take to further reduce the predictability of state nursing home surveys?

Answer:

CMS plans to further reduce the predictability of state nursing home surveys through the addition of a new automated scheduling and tracking information system. This system will enable states to facilitate scheduling and monitoring of the survey process. CMS will be able to use this system to assist states in scheduling surveys and varying the timing of the survey so that surveyors have a better chance of obtaining a more accurate view of how each nursing home functions (because nursing homes do not expect the survey and cannot prepare for it).

I was surprised to learn that CMS was still in an "evaluation" rather than an "implementation" mode for a new nursing home survey methodology that has been under development since 1998. Why has its development taken so long? Can you assure me that CMS is committed to addressing the survey methodology weaknesses that GAO first identified in 1998?

Answer:

In 1998, CMS changed its current survey process to focus more on nutrition, hydration, pressure ulcers and preventing abuse. At the same time, CMS also began work on a future major revision to the survey process in early 1999 that would remedy some

concerns raised by consumer advocates and nursing home professionals. One concern raised was that the current survey process looked at a relatively small sample of nursing home residents in its inspection process. The revised survey process will capture a much larger sample to overcome this vulnerability.

The evaluation is not a paper exercise; it is an actual implementation in pilot states. It is this implementation that is being evaluated in order to answer important questions before any national implementation.

I understand that the revised survey process is complex and represents a critical role in determining the quality of care in our nation's nursing homes. Because of the importance and complexity, CMS has spent a great deal of effort in developing a survey process that will be superior to the current system while staying within the survey and certification budget. Likewise, time spent to test the revised process is vital before implementing it nationally. CMS is now implementing a multi-State demonstration of this revised process. Unlike previous research projects, this demonstration is an actual implementation of the survey of record. I will work with CMS to ensure that we survey methodology weaknesses are addressed and we continue to strengthen the process.

Assuring the Quality of Kidney Dialysis Care

End-stage renal disease (ESRD) patients represent a rapidly growing segment of the Medicare program. Roughly 300,000 ESRD beneficiaries rely on dialysis services today, with studies projecting these patients to grow to more than 500,000 by the end of the decade. A recent GAO report found that a substantial number of dialysis facilities do not achieve the minimum patient outcomes specified in clinical practice guidelines for a significant proportion of their patients. In addition, 15 percent of facility surveys conducted in the past five years showed serious quality problems that, if uncorrected, would warrant termination from the Medicare program.

The Committee would like to know what steps you would take to ensure that dialysis facilities are providing quality care to their patients. Specifically,

CMS funding for ESRD facility inspections reached an estimated $8.2 million in 2002, only 2 percent of all federal support for state survey and certification activities. How will you make sure that states' survey agencies monitor all facilities on a regular basis while targeting for more frequent inspections those ESRD facilities with a history of serious deficiencies?

Answer:

I recognize that state survey and certification activities in end-stage renal disease (ESRD) facilities are critical to help protect the health and well-being of one of the nation's most vulnerable populations. The mission of CMS' survey and certification program for ESRD facilities is to ensure dialysis centers, transplant centers, and organ procurement organizations comply with Federal regulations, thereby ensuring and improving the health and safety of Medicare's ESRD beneficiaries.

The CMS mandates that each state complete inspection surveys of 1/3 of all ESRD facilities annually. Over a three-year period, the agency expects that each ESRD facility will be inspected. Further, CMS provides each state with a report describing the quality aspects of each dialysis facility in their state. The report compares each facility against other facilities in the state and against national averages. Each state is also provided with a rank-ordered listing of facilities. These lists are used by the states for targeting and focusing inspection activities. These are critical activities that I would continue to support, if confirmed.

In 2002, CMS spent about $24.7 million, or three times its budget for dialysis facility inspections, to fund ESRD networks-organizations authorized to conduct quality improvement projects and monitor clinical performance. How would you reconcile the imbalance in CMS's oversight and consultative approaches to quality assurance activities?

Answer:

Improving the quality of health care can be achieved in a variety of ways—through inspections as well as quality improvement initiatives. As you know, these two activities are subject to different funding processes. While the ESRD Network budget is statutorily defined, survey and certification activities for ESRD facilities are determined through the annual congressional budget appropriations process. If confirmed, I will examine the relationship between oversight and quality improvement more closely and hope to work with the Congress on this issue to ensure that appropriate actions are taken to help protect the health and well-being of Medicare beneficiaries receiving ESRD services.

Consumer Information on ESRD Facility Quality

Informing consumers about the quality of care provided by ESRD facilities is an important component in a well-functioning health care market. In 2001, in response to a Congressional mandate, CMS established Dialysis Facility Compare, an Internet Web site to help beneficiaries decide where to obtain dialysis services. The site provides information on each facility's location, hours, and size, as well as data on several clinical measures of quality. However, consumer groups have noted that the information is woefully out of date and does not allow the user to clearly differentiate among providers.

GAO has recommended that CMS expand the information available on Dialysis Facility Compare to include the results of state surveys. (Similar information is currently disseminated on CMS's Nursing Home Compare Web site.) This would not only improve the value of the Web site to consumers but would create an incentive for providers to maintain compliance with Medicare regulations.

As the Secretary, would you consider publicizing dialysis survey outcomes to help inform beneficiaries and drive quality in the industry?

Answer:

Improving health care quality is a key priority for me. As you know, this Administration has worked to assure quality health care for all Americans. While I am not prepared to commit to any specific proposal today,, I will closely examine this issue to ensure that consumers have information allowing them to make more informed decisions regarding their health care. I understand that the Dialysis Facility Compare (DFC) tool on the www.medicare.gov website allows consumers to review and compare facility characteristics and quality information on all Medicare approved dialysis facilities in the United States. This information can help consumers, especially dialysis patients, choose a dialysis facility that meets their needs and stimulate patients to discuss this information with their dialysis care giver. The website also works to drive quality improvement efforts within the dialysis industry by publicly reporting facility-specific information.

DME Competitive Bidding:

The MMA mandated the competitive acquisition of certain durable medical equipment (DME) supplies and services. Competitive acquisition programs will be phased in starting in 2007.

Secretary Thompson established a program advisory and oversight committee to discuss implementation issues of the DME competitive bidding process. Is there a strategic plan for effectively implementing DME competitive bidding in the 10 largest metropolitan statistical areas starting in 2007? Has the established committee provided advice on different implementation issues – and has this advice been considered by the Department? What are your views on competitive bidding for DME and how will you ensure that small suppliers in rural areas are not negatively affected in the long run?

Answer:

The DME Competitive Bidding/Acquisition program is underway. The Program Advisory and Oversight Committee (PAOC) that was established to provide advice on the implementation of the Competitive Acquisition Program; establishment of financial standards that take into account the needs of small providers; establishment of requirements for collection of data for the efficient management of the program; development of proposals for efficient interaction among manufacturers, providers of services, suppliers, and individuals; and establishment of quality standards has met twice already. The PAOC has provided advice to CMS and CMS is now considering this guidance as it drafts the Notice of Proposed Rulemaking.

The timeline for the DME Competitive Acquisition Program is as follows:

- Summer 2005 - CMS plans to issue a Notice of Proposed Rulemaking

- Fall 2005 – Public comment period for the NPRM on Competitive Bidding will occur
- Winter 2005 – CMS completes review of comments and discusses outstanding issues
- Summer 2006 - After completing all agency and department clearance, Final Rule for National Competitive Bidding will be effective
- January 2007 – Initiate National Competitive Bidding for certain durable medical equipment, prosthetics, orthotics, and supplies in 10 of the largest MSAs.

I believe that competitive bidding will reduce beneficiary and Medicare program costs for DME while protecting beneficiary access to quality DME, and that it is important to ensure that small suppliers in rural areas are protected and able to compete in the program.

Leavitt Confirmation
Grassley Questions for the Record

$1 billion in funding for Medicare Modernization Act (MMA) Oversight and Implementation Activities

At the risk of understatement, the MMA greatly expanded the responsibilities of the Department and the Centers for Medicare and Medicaid Services. The Department will have ultimate responsibility for overseeing and administering the new voluntary prescription drug benefit and Medicare Advantage program.

Congress recognized that the Department would need adequate financial resources to meet these new obligations successfully. Accordingly, Congress provided the Department with $1 billion for these purposes.

Could you provide the Committee with an accounting of the funds made available to the Department and the decision process for allocating funding to various activities? In addition, would you please provide the plan for the remainder of this funding?

Answer:

One of the leading priorities of mine as Secretary will be to effectively implement the landmark Medicare Modernization Act. As you noted, Congress recognized the resource needs that this sweeping legislation would demand, and provided $1 billion to fulfill these obligations. CMS has a very robust plan to spend the $1 billion MMA implementation appropriation. The prime directive in allocating these funds will be to ensure that the new benefits and programs that the MMA made available for our beneficiaries are implemented on time and efficiently.

These are a few of the major priorities:

- Enhancing Beneficiary and Provider Outreach - $436 million, 44 Percent. The only way that the MMA will be successful is if we are successful in educating our beneficiaries, providers and other partners about how the MMA will impact them.

  Our investments in this area include: enhancing the functionality and availability of 1-800-MEDICARE, creating new functionality for our web sites, expanding our capacity - through local partnerships - to interact on a 1:1 basis with our beneficiaries and creating an information sharing network to ensure that employers, providers and plans understand the implications of the MMA.

- Staffing CMS to Meet the Mandates of MMA -- $44million, or only 4.4 percent. CMS' current human capital investments are correct for the pre-MMA world. However, MMA drives us to a new way of doing business and we want a workforce that has the skills and knowledge to interact effectively in this new environment, be responsive to beneficiary needs, and provide leadership for all of our providers and partners.

We believe that up to 500 (on a base of 4,580) new FTE will be needed who: have experience with our new business partners, are versed in cutting edge outreach and education methods, have superior analytic skills for fraud detection and are on the cutting edge of the latest information technology.

- Using Private Sector Technology and Expertise to Drive Efficient Implementation -- $276 million, 28 percent. We are making prudent investments in an information technology framework that will allow CMS to carryout its current obligations as well as implement MMA's reforms.

  Our information technology strategy: relies on investing in provide internet-based technologies to provide and process information, leverages existing technology to ensure that we are not duplicating systems, seeks voluntary partnerships with providers, plans and employers to decrease overall cost, and builds-in security and confidentially.

- Combat Fraud - $25 million, 2.5 percent. The Departments Office of Inspector General has been provided funding for this oversight role.

Plans for formulary review

Making sure that beneficiaries have access to the medicines they need is a paramount issue for me. I raised this issue with Administrator McClellan at last fall's Finance hearing on the MMA and in a follow-up letter to him as well.

While the MMA allows plans to develop their own formularies, the formularies must meet certain rules and requirements. I was pleased that CMS issued additional guidance on the process it plans to use in reviewing formularies.

Could you please tell me, though, about how the Department will 'operationalize' that plan? Have you hired personnel with expertise in reviewing formularies, for example? Perhaps you could walk me through a formulary review – the steps that will be taken and who actually will be conducting the reviews.

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. We intend to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries and that vulnerable groups are not discriminated against in drug selection or through co-pays.

Per a requirement in the MMA, CMS has requested the U.S. Pharmacopeia (USP) to develop a model set of guidelines consisting of a list of drug categories and classes that may be used by plans to develop formularies for their Part D coverage, including their

therapeutic categories and classes. The USP listing will simply serve as a model set of guidelines, however. Plans will have the flexibility to develop their own formulary classification schemes. However, to the extent that a PDP sponsor or MA organization offering an MA-PD plan designs its formulary using therapeutic classes and categories that vary from the USP classification model, we will evaluate the submitted formulary design to ensure that it does not substantially discourage enrollment by certain Part D eligible individuals.

Follow-Up:

What will happen if the Agency determines that a formulary is in fact discriminatory? How will CMS deal with the PDP or MA-PD to address that situation?

Answer:

One of my priorities in implementing the MMA will be to ensure that any formulary that is offered is not discriminatory; and key to this process will be a vigorous review process conducted by CMS to identify formularies that do not provide a sufficient range of drugs for all Medicare beneficiaries or that discriminate against a vulnerable group of beneficiaries. As required in the MMA, formularies that discourage enrollment for certain types of beneficiaries will not be permitted.

Pharmacy Network

When we were working on the MMA, beneficiaries in Iowa told me that having good access to their local pharmacy was very important to them. In some cases, generations have been using the same pharmacy. They know and trust their pharmacist.

The MMA requires prescription drug plans and MA prescription drug plans to meet the TriCare retail pharmacy access standards.

Can you tell me, though, if networks will be monitored – for example, how will complaints about network adequacy be tracked? And what actions will be taken?

Answer:

First, CMS will review plan networks during the application process. CMS will use mapping software to review plan networks to ensure that the Tricare pharmacy access standards are met. After the program is up and running, CMS will be monitoring complaints to regional offices as well as feedback from 1-800-MEDICARE representatives and SHIP staffs and will follow up with plan sponsors to ensure that they are providing the statutory level of access.

Follow-Up:

What other level of review will be applied in determining whether a plan's network is adequate? For example, the final rule permits differential cost-sharing – or preferred and non-preferred pharmacies.

Isn't it conceivable that a prescription drug plan could meet the TriCare standard, but with pharmacies that have higher cost-sharing? If that's the case, a beneficiary might not have as good access as Congress intended? Could you comment on what type of oversight will take place to ensure that that doesn't happen?

Answer:

It is true that plans have the ability to charge different cost sharing within their pharmacy networks. The CMS review of plan networks will include a check to ensure that plans have not systematically structured their networks to exclude areas from their preferred networks.

Auto-Enrollment for Dual-Eligibles

As you know, beneficiaries who currently have Medicaid prescription drug coverage will have coverage under the new Medicare drug benefit on January 1st 2006.

There are numerous transition issues for the dual eligibles. One potential problem is a gap in coverage from the time when Medicaid coverage ends and Part D coverage begins. We clearly need to avoid that outcome. Last fall, Dr. McClellan stated that the Agency would work to implement a strategy that will ensure a smoother transition for dual-eligibles.

Can you give me a status report on plans to provide for a smoother transition? In the context of Medicaid reform, what is your vision for how to better coordinate coverage, benefits, and care delivery for the dual eligible population?

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

National Education Campaign

Last spring, I hosted more than 40 town hall meeting throughout Iowa on the Medicare law. I talked about the drug card program and the new drug benefit.

If I learned anything from those meetings, I learned that beneficiaries have good questions and they need good information about the benefit. But it's not only the beneficiaries themselves who need this information. Their children and caregivers and other people who help them make health care decisions need information too.

Can you tell me about the Department's strategy to educate beneficiaries, caregivers, family members and even health professionals about the prescription drug benefit and the MA program?

Answer:

As you know, the Department has taken a number of steps to educate beneficiaries, caregivers, family members and even health professionals about the prescription drug benefit and the MA program; and I am committed to continuing and improving this process so that individuals understand the new Medicare benefits and how to get the most out of them. Some of the steps that have been taken are listed below.

Beneficiaries:
CMS has taken many steps to help beneficiaries get the personalized assistance they need to get the most out of Medicare's expanded benefits. These include enhancements to 1-800-MEDICARE so that beneficiaries can get additional support in identifying the best drug and health plan options for their needs. CMS has increased the number of customer service representatives (csrs) from several hundred to 3,000 as of June 2004, and expects to maintain this number of trained personnel to handle the unprecedented number of callers in a timely and effective manner. CMS has also added pre-recorded voice messages to help beneficiaries be better prepared when they call, further reducing waiting and handling time.

Publications are available online at www.medicare.gov, and numerous mailings have previously been sent to beneficiaries to help them learn about, and enroll in, Medicare-approved drug discount cards. Additionally, CMS mailed *Medicare & You 2005* handbooks to beneficiaries and stakeholders in the fall of 2004. Handbooks are offered in English, Spanish, Braille, audiotape, and large print.

The CMS national advertising campaign uses television, radio, print, and Internet advertising to inform and motivate beneficiaries and their caregivers to call 1-800-MEDICARE, visit www.medicare.gov, and refer to the *Medicare & You* Handbook for answers to their Medicare questions.

For beneficiaries who require or prefer face-to-face personalized assistance, CMS has also enhanced its partnership with the State Health Insurance Assistance Programs

(ships). CMS increased SHIP funding in 2004 and will provide $31.7 million to ships in 2005, reflecting the increased emphasis on one-on-one advice and counseling for Medicare beneficiaries. The ships are among the most effective resources in helping beneficiaries learn about the changes to Medicare and will use the additional funds to equip local organizations with the tools needed to answer beneficiaries' questions.

CMS also conducts the Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated educational and publicity effort implemented on the local level by CMS' 10 Regional Offices through their partners. The purpose of the campaign is to insure that people with Medicare who have low incomes or who may not be reached by the National Media Campaign due to barriers of location, literacy, language and/or culture, know how and where to get their questions answered, receive culturally and linguistically appropriate information, and receive accurate and reliable information tailored to meet community needs. CMS is also supporting non-profit community-based organizations to help educate and assist low-income beneficiaries who may otherwise be hard to reach.

SCHIP Funding Shortfalls

Many states, including Iowa are facing a shortfall of funds for their State Children's Health Insurance Program or SCHIP, over the next three years, while a number of states have balances 200 - 300 times their expected need.

As Secretary, what steps will you take to address the issue of state shortfalls as well as states that have more SCHIP than they are projected to expend?

Answer:

Secretary Thompson's recent action, based on states projections of their spending in FY 2005, assured that no state will experience a funding shortfall this fiscal year. SCHIP has been highly successful but as you indicate, we still find large surpluses in some states while others face shortfalls in the coming years.

I recall that in 1997 when Congress created SCHIP many understood that it was a challenge to set the allotments at the optimum levels because national data was and continues to be imperfect when it comes to distributing funds across 50 states, the District, and the Territories. Congress was generous in setting the total amount of the allotments, authorizing roughly twice the amount of money needed to cover uninsured children in families below 200% of the federal poverty level. Today, in the aggregate, there is still twice the amount of money in SCHIP as a whole than what states are using. At the same time, however, individual states will likely face shortfalls in the coming years.

I assure you that improving and protecting SCHIP is a priority for me, and I look forward to working with Congress to re-authorize SCHIP and to assure stability in the program

SCHIP Shortfalls and Medicaid Reform

Some have suggested that given the issues associated with the SCHIP formula are compelling enough to warrant increased attention to SCHIP, including, perhaps an attempt to reauthorize this program during the 109th session of Congress. It strikes me that the Congress will need to fix the problem with states that do not have sufficient SCHIP funds to continue their current level of services. What are your thoughts on the viability of addressing SCHIP formula issues outside of the context of reauthorization? Do you see an accelerated reauthorization of SCHIP as integral to a broader discussion of Medicaid, including reform?

Answer:

As Secretary, I assure you that SCHIP will be a priority and I look forward to working with you to explore potential ways to address SCHIP formula issues outside of reauthorization. I also look forward to discussing with you whether or not an accelerated reauthorization process is a potential option to address the formula issues.

SCHIP Outreach and Enrollment Efforts

President Bush has spoken about the need for Medicaid and SCHIP outreach. The President has referred to $1 billion in outreach. In your view would this money be used to enroll both mothers and children in Medicaid and SCHIP? How would you respond to concerns that states are already struggling, fiscally, and increased outreach and enrollment would contribute to these fiscal shortfalls?

Answer:

It will be one of my highest priorities to work with Congress to increase access to quality, affordable health insurance coverage to all Americans. This focus should start, as the President said last summer, with finding and enrolling children who are already eligible for Medicaid and SCHIP.

The President has proposed $1 billion for the "Cover the Kids" campaign, a two-year program to help enroll the millions of low-income children who are eligible, but not signed up, for quality coverage, and to reward states that are successful in doing so.

This campaign will use the resources of the Federal Government, States, schools, and community organizations to implement proven methods to enroll more kids. We will expand on successful approaches to enlist community groups, schools, faith-based organizations, states, IHS, Tribes, Tribal organizations, and urban Indian organizations in targeted outreach efforts to enroll eligible children in SCHIP and provide more coverage. Furthermore, to provide an additional incentive to enroll uninsured children, performance-based grants will be provided to states that exceed their projected enrollment in Medicaid and SCHIP.

The goal of the State Children's Health Insurance Program (SCHIP) is to expand health insurance coverage to low-income children. The year before President Bush took office, some 3.3 million children were enrolled in SCHIP. By 2003, that number had risen to 5.8 million, a 75 percent increase. Despite these efforts, millions of children who are eligible for SCHIP are not yet enrolled and billions in federal dollars available to states to insure these children remain unspent.

Experience has shown that reaching parents increases the enrollment of children, so that is a strategy well worth pursuing. Insuring mothers may also increase health care access to children, which has led some states to expand their Medicaid and SCHIP programs to include adults. States that have expanded outreach to low-income adults will likely use outreach funds for campaigns targeting children and their parents. Additionally, building upon existing model outreach practices and proven strategies identified by states, as well as forging public and private partnerships, are a means of making the most efficient use of state resources. Efforts targeting specific communities or specific age groups have been found to be effective for reaching un-enrolled populations. Outreach funding could be targeted primarily to those individuals that have not been reached to date.

While states have had financial difficulties, many are experiencing recoveries and are seeking ways to cover new children in SCHIP. Clearly, as optional spending under Medicaid continues to grow, time and again states demonstrate that health insurance for low income families is a public priority. This makes me optimistic that states will respond favorably.

1115 Waivers -- Utah's Medicaid waiver

As you know, on February 9, 2002, HHS Secretary Thompson approved a waiver to allow Utah to extend coverage under their Medicaid program to 25,000 uninsured adults, while reducing benefits to existing adult beneficiaries.

Under this waiver, Utah is able to extend Medicaid coverage to uninsured adults at 150% of poverty. This expansion population pays a $50 enrollment fee and receives a benefits package that covers primary and preventative care. The package does not cover in-patient hospital care, although as part of the negotiations during the development of the waiver, Utah's hospitals agreed to provide $10 million a year towards the costs associated with caring for the expansion population's hospital care.

The premise of the waiver was that preventative care was more cost effective and provided better health outcomes than catastrophic or emergency care. The goal was to provide low-income adults with a policy that was comparable to the policy that state employees received.

As you know, most health analysts conclude that over the course of several years, preventative care is more cost effective and provides better health coverage than simply providing illness care and catastrophic benefits.

Can you speak broadly to your experience as Governor about the conditions in Utah that led officials to conclude that the waiver was needed?

Additionally, as you know, some have been critical of the budget neutrality elements of the waiver. It seems to me that the savings that would be achieved by providing preventative care would be difficult to quantify, especially in a relatively short time frame. Do you concur? Can you elaborate?

Answer:

In regards to the Utah waiver itself, please understand that at the time the waiver was conceived, Utah had a very successful State Children's Health Insurance program that contributed to the reduction in the rate of un-insurance for children in Utah. The overall uninsured rate in Utah as of February 2002 was approximately 9 percent and was even lower for children, at approximately 7.3 percent. With this successful initiative to build on, I thought that it was time to address health care access for low-income working adults who have no health insurance coverage at all. Within the 9 percent of Utahans who remained uninsured, approximately 152,000 individuals were between the ages of 18 and 64. The waiver allowed Utah to reach approximately 25,000 of these individuals with a limited health care benefit. We expected the waiver program to reduce the number of uninsured in this age group by over 16 percent.

It made sense to me to get basic health care coverage to as many people as possible, and this is how we did it. We made very basic coverage available to working Utahns who otherwise could not afford insurance.

As you point out, our approach was on the front end of prevention and access to basic health care rather than the back end of simply paying bills after individuals got sick. Our approach included measures to get individuals involved in their own health status and decision-making. Like all 1115 demonstrations, the Utah waiver will be evaluated. At this point, I believe it is a success because the people of Utah are signing up for it and as State finances improve, more will sign up.

Some fail to understand that the "all or nothing" approach to Medicaid is actually a barrier to expansion of basic and preventive care. With tens of millions of Americans still uninsured, states must be allowed to pursue different approaches. That is what demonstrations are about.

It is, as you note, difficult to quantify the value of a preventive approach, but perhaps one day our analytic models will catch up to the old adage of medicine, an apple a day keeps the doctor away. We should not shy away from these commonsense approaches simply

because we have not developed economic models sophisticated and sensitive enough to prove their worth.

Welfare

Utah's model for coordination of services for low-income families and families that receive assistance, served as the model for a number of proposals for Universal Engagement in several versions of the legislation to reform the welfare system. Can you comment on your experience with program integration in Utah and whether or not you intend to advance the lessons learned as Governor?

Answer:

I believe the organizing principle for programs should be the service needs of families. Families often have multiple needs. Effective service requires an integrated service delivery response across a variety of programs and funding sources.

In Utah, I worked to fully integrate our TANF program, known as the Family Employment Program, with workforce development programs so that families could get help in finding and maintaining employment, time-limited cash assistance, and critical support services like health insurance and child care through a single, seamless process. These services are all provided in Utah by the Department of Workforce Services through our Employment Centers.

It is important that each family be actively engaged in productive activities and that each family has a self-sufficiency plan that guides their activities. In order to stress the program's employment focus, assessment and planning occurs in Utah prior to an eligibility interview. Every parent is expected to participate in appropriate activities, beginning with the initial contact. There are no exemptions, although temporary deferments are provided for illness, medical problems, and to search for quality childcare. Employment plans are individualized to reflect the needs of each family.

To assure efficient coordination and accountability, it is also important to have information and reporting systems that integrate vital program and performance information. In Utah, we developed a case management system known as UWORKS that bring together information from workforce programs, TANF and others and communicates with the public assistance case management eligibility system (PACMIS).

Success in helping low-income families achieve self-sufficiency requires a careful blend of state flexibility and strong accountability. In Utah we were able to develop innovative approaches to meeting this challenge. I look forward to sharing these lessons learned with our State partners and continuing to learn from their efforts to meet these challenges.

Chronic Care Improvement Program (CCIP)

The MMA authorized development and testing of voluntary chronic care improvement programs (CCIPs) to improve the quality of care and quality of life for people living with multiple chronic conditions. On December 8, 2004 Medicare announced the selection of nine organizations to operate three-year pilot programs. The first program is scheduled to begin in the spring of 2005.

As these health care organizations move towards implementation of their chronic care improvement programs, do you believe these programs will provide significant savings under the Medicare program?

I understand that the MMA requires budget neutrality for these programs, but that CMS decided to require 5% savings under . The exact amount of savings will depend on a number of unknown variables such as the total number of beneficiaries who choose to participate in the programs. The requirement for savings reflects the belief of the Administration that shifting resources to prevention can improve both clinical and financial outcomes.

Are there additional steps the Department can take to educate Medicare beneficiaries of these new programs besides the initial enrollment letter?

I believe it is crucial that we work aggressively to educate Medicare beneficiaries of the new programs and new options that are available to them, and intend to work with CMS to ensure that beneficiaries learn about this program.

Because the Secretary has the responsibility of deciding whether a program qualifies for expansion, what benchmarks should be used to make this determination?

As you know, CCIP is designed as a two-phased initiative. Phase I is a pilot phase that will operate for three years and be evaluated through randomized controlled trials. Phase II is the expansion phase, in which programs or program components that have proven to be successful in improving clinical outcomes, increasing beneficiary satisfaction, and meeting Medicare spending targets for their assigned populations may be expanded.

It should be noted that the Medicare program already has several chronic care management demonstrations underway - does the Department have plans to coordinate these various demonstrations?

What is your long-range vision for the role of chronic care management in the Medicare program?

The Chronic Care Improvement Program will lead Medicare toward a stronger focus on improving health outcomes for prospectively identified target populations who are not well served by the fragmented FFS health care delivery system. Chronic Care Improvement will lead Medicare toward addressing quality failings without changing beneficiary's benefits, providers, or access to care.
In the long-run, chronic care management will help modernize Medicare by creating incentives for the private sector to harness advances in information technology and innovation in care management on behalf of FFS Medicare beneficiaries.

Physician Fee Schedule

While the MMA avoided scheduled cuts to physicians in 2004 and 2005, CMS actuaries' project payment updates of negative 5 percent annually from 2006 to 2012. In order to avoid the scheduled cuts and eliminate the sustainable growth rate (SGR) formula, the Congressional Budget Office estimates it will cost approximately $100 billion over 10 years. One of the proposed solutions is to remove prescription drug expenditures from the physician payment formula retroactive to 1996. This would be a significant cost to the Administration, but would provide positive updates to the physicians starting in 2006.

Governor, what are your thoughts on what the Department should do to avoid the scheduled cuts to Medicare participating physicians? Do you believe the Department should take steps to fix the formula administratively?

Answer:

I understand that Medicare uses a complex formula to determine the update for physicians. My understanding is that the statutory formula will result in several consecutive years of negative updates for physicians beginning in 2006. While I understand that this is a complicated issue, I haven't gotten into the details of this issue and I'm not prepared to endorse any particular solution today. I would certainly want to see if there are steps that could be taken administratively that could help deal with the issue, and I look forward to working on this issue if confirmed.

A letter was sent on May 27, 2004 to CMS regarding possible administrative fixes to the sustainable growth rate (SGR) payment formula. I received a response on September 13, 2004; however, I was hoping to receive a more detailed response to the following:

1) **Impact of removing prescription drug expenditures from the physician payment formula retroactive to 1996 and its affect on the physician payment update over ten years.**

Answer:

CMS actuaries estimate the 10-year costs of removing drugs from the physician update formula retroactively to 1996 to be $119 billion over 10 years under the FY 2005 Mid-Session baseline. Last year, the actuarial estimates of SGR proposals were higher than CBO's estimates. The year-by-year physician updates under this proposal were estimated to be: 3.7 percent in 2006; 1.9 percent in 2007; -0.2 percent in 2008; -0.4 percent in 2009; 0.5 percent in 2010; 1.1 percent in 2011; 1.3 percent in 2012; 1.6 percent in 2013; and 1.6 percent in 2014.

Note that physician update system is extremely volatile; the estimated updates from such a proposal could change significantly under the FY 2006 President's Budget baseline. And the actual updates may vary quite a bit from these estimates. Updated actuarial figures using the FY 2006 President's Budget baseline will be available after this year's President's Budget is released.

2) **The impact of "ripple effects" caused by certain provisions in the MMA, including the prescription drug benefit and new preventive benefits.**

Answer:

The statute requires adjusting the physician update formula for changes in law or regulation affecting the physician spending baseline. CMS actuaries make this adjustment based on the entire estimated effect of each proposal impacting the physician update system. Note that the estimated impact on the physician update system due to changes in law and regulation can be revised for two years after the change is first included in the update formula.

CMS actuaries have not assumed an impact on physicians' services for the new prescription drug benefit. This assumption was reviewed by the 2004 Technical Review Panel on the Medicare Trustees Report and determined to be reasonable.

3) **A re-evaluation of projections regarding the extent of private plan participation in Medicare by CMS actuaries' and how this will affect the baseline.**

Answer:

Response: The 2004 Technical Review Panel evaluated the actuaries assumption about participation in the Medicare Advantage program. The Panel felt that the ultimate participation rate of about 32 percent was reasonable. However, they recommended that such ultimate participation rate be reached more slowly. This recommendation will be reflected in the FY 2006 President's Budget. While this will improve the estimated updates in the baseline, the magnitude of this impact is very small.

I give you my commitment to working to provide you with a more detailed response to these questions.

Medicare Obesity Coverage Policy

Secretary Tommy Thompson announced on July 15, 2004 a new Medicare coverage policy that would remove barriers to covering anti-obesity interventions if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes. The public can now submit requests for coverage of obesity treatments, which Medicare will review.

Once obesity treatments are approved for coverage, do you believe there will be a significant increase in utilization of these treatments? Given that the CDC has found that, in 1999, 61 percent of adults were considered overweight or obese, will coverage of these treatments increase Medicare spending significantly due to the high percentage of adults who are overweight or obese?

Answer:

Obesity is a critical public health problem in our country that causes millions of Americans to suffer unnecessary health problems and to die prematurely. Treating obesity-related illnesses and complications adds billions of dollars to the nation's health care costs. The new policy enables Medicare to review scientific evidence in order to determine which interventions improve health outcomes for seniors and disabled Americans who are obese. The Centers for Medicare & Medicaid Services (CMS) has a clear, established process for determining coverage of new items or services under Medicare that is driven by clinical and scientific data. Medicare would only cover treatments for obesity-related illnesses if there is evidence that such treatments are effective for the Medicare population. The medical science will determine whether we provide coverage for the treatments that reduce complications and improve quality of life for the millions of Medicare beneficiaries who are obese.

Food and Drug Administration

What, in your opinion, is the role/mission of the FDA?

Answer:

The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods safer and more effective; and helping the public get the accurate, science-based information they need to use medicines and foods to improve their health.

Over the last few months, there has been a series of public announcements regarding newly discovered risks in FDA-approved drugs. What is your opinion regarding FDA's ability to assess the safety of drugs and to monitor them once they are on the market?

Answer:

It is well recognized that FDA's drug review is a gold standard. I believe that FDA maintains the highest standards worldwide for approval and post-marketing monitoring of drugs. FDA has created a strong post-market drug safety program designed to assess adverse events identified after approval when drugs become available to the general public. I know that the FDA is sponsoring an Institute of Medicine (IOM) study on the effectiveness of the United States' drug safety system, with an emphasis on drugs as they are actually used. I look forward to reviewing the results of this study and to working with the FDA and the Congress to further improve the ability of the FDA to monitor and respond to drug safety issues.

In the case of VIOXX, nearly 2 years passed before the label was changed to incorporate new data regarding cardiovascular risks. During that period the manufacturer of Vioxx proceeded to heavily market Vioxx to consumers and physicians continued to prescribe the medication without knowledge of that data. What is your opinion of FDA's ability to promptly inform the medical and scientific community and/or the public of new information regarding drug risks?

Answer:

FDA has a commitment to keeping the medical and scientific community and the public informed of new information regarding drug risks. FDA's Office of New Drugs works in close collaboration with the Office of Drug Safety to evaluate post-marketing adverse events and take action when needed. Even so, on November 5, 2004, the Acting Commissioner of FDA announced additional steps to strengthen this program in the form of a major initiative designed to improve the monitoring of drug products recently approved for marketing. The major components of this initiative include:

- Sponsoring a major study of the Drug Safety System by the prestigious Institute of Medicine;
- Conducting a nationwide search to identify a permanent director for the Office of Drug Safety;
- Conducting a series of workshops and meetings on drug safety and risk management; and
- Publishing risk management guidances.

What actions would you take to address problems in FDA's drug review and post-marketing surveillance process?

Answer:

As you know, on November 5, 2004, FDA announced a five-step plan to strengthen its drug safety program. First, CDER is sponsoring an IOM study on FDA's drug safety system. An IOM committee will study the effectiveness of the United States' drug safety system, with an emphasis on the drugs as they are actually used. We will ask IOM to examine FDA' role within the health care delivery system and recommend measures to enhance the confidence of Americans in the safety and effectiveness of their drugs.

Second, CDER will implement a program for addressing differences of professional opinion. In an effort to improve the current process, CDER will formalize a program to help ensure that the opinions of dissenting scientific reviewers are formally addressed and transparent in its decision-making process. An ad hoc panel, including FDA staff and outside experts not directly involved in disputed decision, will have 30 days to review all relevant materials and recommend to the Center Director an appropriate course of action.

Third, CDER will conduct a national search to fill the currently vacant position of Director of the Office of Drug Safety, which is responsible for overseeing the post-marketing safety program for all drugs.

Fourth, in the coming year, CDER will conduct workshops and Advisory Committee meetings to discuss complex drug safety and risk management issues. These consultations may include emerging concerns for products that are investigational or already marketed, and will include experts from FDA, other federal agencies, academia, the pharmaceutical industry, and the healthcare community.

Finally, FDA intends to soon publish final versions of three guidances that the agency developed to help pharmaceutical firms manage risks involving drugs and biological products. These guidances should assist pharmaceutical firms in identifying and assessing potential safety risks not only before a drug reaches the market but also after a drug is already on the market. These documents are:

- Premarketing Guidance that covers risk assessment prior to their marketing;
- RiskMAP Guidance that deals with the development and use of risk-minimization actions plans; and
- Pharmacovigilance Guidance that discusses post-marketing risk assessment, good pharmacovigilance practices and pharmacoepidemiologic assessment.

I look forward to reviewing these steps and working with the FDA and the Congress to determine what, if any, additional steps may be necessary.

What is your position on convening an independent commission of experts to recommend changes that could enhance drug safety in the United States?

Answer:

As stated above, CDER is sponsoring an IOM study on FDA's drug safety system. An IOM committee will study the effectiveness of the United States' drug safety system, with an emphasis on the drugs as they are actually used. I look forward to reviewing the results of this study and to working with the FDA and the Congress to further improve the ability of the FDA to monitor and respond to drug safety issues.

What is your position on providing FDA's Office of Drug Safety with independent authority from the agency's Center for Drug Evaluation and Research?

Answer:

The FDA is responsible for regulating drugs and ensuring their safety throughout their entire life cycle, beginning when the drug is first tested in humans and continuing even when a drug has made it to the marketplace. I understand that FDA's Office of Drug Safety (ODS) is already an independent office separate from the Office of New Drugs, the office that reviews new drug applications. I believe we should move carefully before undertaking any restructuring, and look forward to reviewing the results of the IOM study looking into these matters, as well as working with FDA, Congress and outside stakeholders to ensure an efficient and effective system of drug regulation.

Given the bias against publication of negative clinical study results, what is your position with regards to a mandatory clinical trials data registry/clinical trial results database?

Answer:

I believe that patients and physicians should have as much information necessary to guide treatment decisions, and that results of trials involving human subjects should be made available to the public. Government, academic, or industry groups may sponsor human trials and each of these sponsors has a role in making clinical trial results available. I welcome a continued dialogue regarding both the kind of information from clinical trials that would be useful to patients, families, and providers, as well as the most appropriate mechanism for sharing this information, so they can make more meaningful treatment decisions.

What is your position on periodic mandatory post-marketing drug reviews?

Answer:

Some have suggested that the United States should develop a system like the European system that would conduct mandatory periodic drug reviews. The benefits and costs associated with such a system would need to be fully explored before a decision could be made about whether to adopt such a system here. The IOM may provide its views on such a system as part of its study.

National Institutes of Health/FDA

The recent media coverage of problems related to the conduct of an AIDS study in Uganda highlights the importance of strengthening oversight of approved clinical studies. What steps would you take to improve the continuing review process?

Answer:

Ensuring the protection of human subjects must be a top priority of the Department and its agencies that conduct and oversee clinical trials. I look forward to reviewing the policies and procedures that are in place and to working with you to ensure that these trials are effectively reviewed and monitored.

Medicaid Payment Error Rate

To more effectively prevent improper payments for Medicare claims, the Centers for Medicare & Medicaid Services (CMS) measures error rates in Medicare payments, collecting contractor-specific information to better identify where errors are being made. Why are payment error rates not also measured for Medicaid? Would you be willing to initiate a process where CMS would also collect date to determine the error rate for Medicaid.

This committee sent a letter in April 2004 to CMS, the HHS Office of the Inspector General, and the Department of Justice requesting the formation of an inter-agency task force to target fraud, waste and abuse within the Medicare drug program. What is the status of that task force?

Answer:

Please be assured that I will take the battle against waste, fraud, and abuse as a top priority. With millions of Americans without health insurance, it is unacceptable to allow public funds to be drained by wasteful practices. Legal action against fraud and abuse will be aggressively pursued.

The first line of defense is at the state level. Since each state's Medicaid program is unique, collecting data to determine the error rate for all state Medicaid programs is extraordinarily complex. However, CMS initiated a project to explore the feasibility of estimating the accuracy of Medicaid payments under a demonstration project titled the Payment Accuracy Measurement (PAM) pilot. The PAM pilot project operated from FY 2002 through FY 2004. State participation was voluntary and evolved from 9 states in the first year to 27 states in the third year. Working with these states, CMS developed a methodology to estimate payment accuracy at the state level for both Medicaid and the State Children's Health Insurance Program (SCHIP) and produced accuracy rates for these programs.

After CMS initiated the PAM demonstration project, Congress passed the Improper Payments Information Act (IPIA) of 2002 (Public Law 107-300) that requires federal agencies to annually estimate improper payments in the programs they oversee. CMS published a proposed regulation in August 2004 to implement the law at the state level. Public comments on the proposed rule were negative primarily due to the cost and burden states would absorb to implement the program. Currently, CMS is researching recommended alternative methods for national implementation of the IPIA.

For FY 2005, CMS switched the payment measurement in Medicaid and SCHIP from payment accuracy to payment error rate (titled the Payment Error Rate Program or PERM). Thirty-two states volunteered to participate in the PERM demonstration project to produce error rates for Medicaid and SCHIP.

CMS worked with its law enforcement partners, both at the HHS Office of the Inspector General (OIG) and the Department of Justice (DOJ) throughout the implementation of the Part D benefit. All parties have worked closely through CMS's regulatory process as it finalized the Prescription Drug Benefit regulation. Both DOJ and HHS OIG provided invaluable comments throughout the process that will strengthen our ability to identify and eliminate fraud, waste, and abuse in the Part D benefit. Additionally, CMS, DOJ and HHS OIG meet on a quarterly basis to discuss programmatic issues and strategies to protect the Part D trust fund. Finally, to assure full collaboration we are holding a CMS/Law Enforcement conference on March 2nd and 3rd 2005. This conference will include presentations from DOJ, HHS OIG, and CMS policy specialists. We anticipate this conference will enhance our current working relationship by allowing each entity to discuss both its constraints within the Part D benefit and strategies each proposes for protecting the Medicare Part D trust fund.

In addition, a Senior Level Interagency Fraud Workgroup meets monthly to discuss program vulnerabilities, current projects, strategies and potential action to detect, mitigate, and prevent fraud, waste and abuse within the Medicare Part D Benefit, as well as other Medicare and Medicaid programs.

Congress/GAO/HHS IG Access Questions

The Constitution established a system of checks and balances intended to ensure the American people of fair, honest and transparent government. Congressional oversight of executive branch operations is a linchpin of the checks and balances system. Oversight of HHS programs and activities require the review of documents and interviews with agency officials, and it is critical that we have timely access to the documents and agency officials to inform our work. In furtherance of our oversight responsibilities, we often ask GAO to evaluate HHS programs and activities. In addition, we may ask the HHS Office of the Inspector General (OIG) to follow up on complaints regarding specific agencies and/or programs.

This Committee, however, has encountered a number of significant and undue delays in response to its requests. A number of requests to the FDA, for example,

remain outstanding and the deadlines have long passed. We are also aware that HHS has from time to time failed to cooperate with the GAO and OIG in a timely and constructive manner.

- **Will you commit to working with the Congress, GAO and the HHS OIG in a timely and constructive manner to address the oversight and other needs of the Congress, and will you encourage others to do so?**

Answer:

Yes. I am committed to working with the Congress, including the GAO, in a timely and constructive manner to address the oversight and other needs of the Congress, and I will encourage others to do so.

- **What specific steps will you take to ensure that the Congress, GAO and HHS OIG receive access to the information and agency officials we need to carry out reviews of HHS programs and activities, and to ensure that information is provided in a timely manner?**

Answer:

I have great respect for the oversight role of Congress, including GAO, particularly with respect to the important programs with which the Department is entrusted. Therefore, if confirmed, I will make timely responsiveness of the entire Department to Congressional inquiries a top priority. I will work to support the work of the Department's Office of Inspector General. I also hope that we will be able to work closely with the Committee on the range of issues of interest to you.

- **Do you foresee any issues in providing particular categories of HHS information to Congress or GAO? If so, what are the issues and how will you address them?**

Answer:

I do not foresee any particular issues in providing categories of HHS information to Congressional Committees, or to GAO when it is exercising its statutory jurisdiction. If any issue were to arise, it would be my intention that the Department work with you and your staff to arrive at an appropriate solution that satisfies your need for information to carry on the oversight work of this Committee and that is consistent with Executive branch policies and practices in such matters.

Administrative Law Judge Transfer

Section 931 of the MMA mandates the transfer of Medicare appeals from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS). Under the law HHS is scheduled to start receiving appeals on July 1st. On

Leavitt Confirmation
Grassley Questions for the Record

October 6, 2004, the Government Accountability Office (GAO) released a report title "Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants."

Could you please tell me what HHS is doing to address the concerns outlined by GAO in their report? Specifically their concern about time frames for establishing regulations for providing appellants the opportunity to file appeals electronically and reliance on videoconferences in lieu of in-person hearings.

Additionally could you please tell me where HHS is in the process of finalizing regulations for the establishment of Qualified Independent Contractors (QICs) mandated in the Benefits Improvement and Protection Act of 2000?

Answer:

Secretary Thompson and the Commissioner of SSA have continued working together to ensure a successful transition and the availability of an efficient and effective appeals process both during the transition and after the transfer of responsibility for the appeals function to HHS is complete. Throughout this ongoing process, HHS has attempted to ensure that GAO and the Congress have the most current information available regarding decisions associated with the transition and the development of the new ALJ appeals entity.

In effort to implement the transfer in an effective and efficient manner, many steps have been taken. To begin with, the Hearings and Appeals Restructuring (HAR) Team was created, which includes senior leadership from across the Department, to provide overall direction and guidance.

Also, on July 25, 2004, the Office of Medicare Hearings and Appeals Transition (OMHAT) was established within the Office of the Secretary/Assistant Secretary for Administration and Management. Since it was established, OMHAT has reviewed and evaluated materials provided by SSA concerning, among other things, workload, training, and processes. Building on this information, OMHAT has completed several actions that further the timely and efficient transfer of the hearings function from SSA. First, OMHAT issued three task orders: one to assess how best to employ videoconferencing and audio-conferencing technologies in the hearings process; one to assess HHS staffing needs for the ALJ hearings function and to develop a weighted workload system; and another to create a simulation of the anticipated case workflow for the Medicare hearings function. Second, OMHAT contracted with "HHS University" (an intra-Department educational network that offers HHS employees training opportunities) for a project manager to oversee the development of all training materials and the scheduling and coordination of training for all new staff associated with the hearings function, and for a complete analysis of HHS' future training needs for staff in the new ALJ appeals entity.

In addition, HHS staff members are actively working with a contractor to develop the documentation and workflow analysis for the ALJ portion of the data system.

The basics of project management involve taking actions to effect a positive outcome, as well as thinking through possible roadblocks, how to prevent them, and what arrangements would be needed if they arise. The Department is assuring that the project management process considers contingencies as one of the many inherent steps in approaching each area of this initiative.

The HHS/SSA transition plan anticipates addressing necessary contingencies. For example, the plan states that HHS will adjust the hiring of ALJs and other staff depending on actual workload volume, and will consider any possible expansion or re-alignment of the initial location of appeals offices depending on experience. Although the GAO report recommends contingencies for all of the MMA transfer plan requirements, several items in the plan, however, do not require specific contingency planning, e.g., regulations, feasibility of precedential authority, independence of ALJs, and performance standards.

The regulations needed for the establishment of Qualified Independent Contractors (QICs) mandated in the Benefits Improvement and Protection Act of 2000 are in the final stages of the clearance process. HHS anticipates publishing the regulation in late February.

DATA REQUESTS

SCHIP -- Final state data on SCHIP as well as a redistribution proposal for the unused 02 allotments.

Response:

Criteria for HHS redistribution of the $643 million in expiring FY 2002 SCHIP funds will be published on Tuesday, January 18.

Section 2104(f) of the Social Security Act requires the Secretary to "determine an appropriate procedure" for redistributing states' unexpended fiscal year (FY) 2002 State Children's Health Insurance Program (SCHIP) allotments remaining at the end of FY 2004 only to those states that fully spent such allotments.

In determining the "appropriate procedure" for reallocating the unused FY 2002 allotments, our primary consideration was to address the unmet SCHIP funding need for each of the redistribution states with respect to FY 2005. These unmet funding needs were determined by considering for each redistribution state: (1) its projected SCHIP related expenditures in FY 2005, as reflected in the states' November 2004 quarterly budget reports; and (2) the total SCHIP allotments available in FY 2005 for the state, exclusive of any FY 2002 redistribution. For a redistribution state whose FY 2005 projected SCHIP related expenditures under (1) were greater than its total available SCHIP allotments under (2), the difference between the projected expenditures and the available allotments represents that state's "shortfall" for FY 2005.

Under the FY 2002 redistribution methodology, we first provide for the "shortfall" amounts needed for those redistribution states that are projected to have insufficient SCHIP funds in FY 2005, as described above. After first providing for the redistribution states' FY 2005 shortfall amounts, the remaining unexpended FY 2002 allotments are redistributed to all of the redistribution states (including the shortfall states) using the same redistribution methodology contained in the SCHIP statute that was applied for determining previous fiscal year redistributions. (This prior year redistribution methodology allocates redistribution amounts based on the difference between the redistribution states' 3 fiscal years of expenditures for the initial period of availability for FY 2002 (that is, FY 2002 through FY 2004) and the states' FY 2002 allotments.)

See the following Tables.

Leavitt Confirmation

Grassley Questions for the Record

TABLE 1 - FY 2005 SHORTFALL CALCULATION

State	FY 2001 Retained/ Redistributed Allotments Carried Over From FY 2004	FY 2003 Allotments Carried Over From FY 2004	FY 2004 Allotments Carried Over From FY 2004	FY 2005 Allotments Initially Available Beginning FY 2005	Total Available Allotments In FY 2005 Not Including FY 2002 Redistribution Col B + C + D + E	Projected Expenditures FY 2005 From Nov. 04 Estimates	Projected FY 2005 Shortfall Not Including FY 2002 Redistribution Col G - F
A	B	C	D	E	F	G	H
Alabama	$0	$38,780,691	$54,679,333	$88,041,101	$181,501,025	$71,988,000 NO Shortfall	
Alaska	$13,108,151	$7,430,466	$7,156,891	$9,020,449	$36,713,946	$18,020,000 NO Shortfall	
Arizona	$0	$0	$20,451,990	$106,473,496	$126,925,186	$174,286,000	$47,360,814
Arkansas	$25,979,819	$34,154,800	$35,073,372	$49,661,567	$144,868,078	$29,414,000 NO Shortfall	
California	$0	$548,807,953	$333,990,797	$867,443,609	$1,750,242,399	$793,753,000 NO Shortfall	
Colorado	$0	$37,914,522	$44,865,429	$57,951,287	$140,731,238	$44,707,000 NO Shortfall	
Connecticut	$2,534,685	$24,361,434	$27,975,129	$36,560,595	$91,431,843	$19,872,000 NO Shortfall	
Delaware	$2,073,863	$8,585,066	$7,817,481	$9,046,920	$27,523,112	$5,863,000 NO Shortfall	
District of Columbia	$0	$7,201,820	$7,196,862	$9,639,097	$24,035,779	$7,994,000 NO Shortfall	
Florida	$132,818,180	$35,421,360	$193,614,857	$249,246,708	$610,901,115	$391,991,000 NO Shortfall	
Georgia	$24,823,464	$0	$103,882,954	$130,918,014	$259,831,452	$191,845,000 NO Shortfall	
Hawaii	$0	$9,647,963	$9,647,963	$12,404,524	$31,700,450	$10,827,000 NO Shortfall	
Idaho	$0	$13,796,479	$15,958,002	$20,747,545	$54,501,026	$17,428,000 NO Shortfall	
Illinois	$0	$69,196,232	$120,899,643	$164,835,525	$345,101,400	$238,955,000 NO Shortfall	
Indiana	$14,670,906	$63,709,869	$54,029,860	$73,421,543	$195,726,997	$73,308,000 NO Shortfall	
Iowa	$0	$5,844,859	$19,703,423	$29,266,206	$56,814,618	$45,668,000 NO Shortfall	
Kansas	$14,962,065	$20,083,084	$23,541,920	$28,479,189	$87,066,258	$42,797,000 NO Shortfall	
Kentucky	$33,743,149	$27,994,481	$39,268,748	$54,080,786	$155,076,145	$75,495,000 NO Shortfall	
Louisiana	$0	$44,240,833	$94,525,176	$77,477,897	$216,241,906	$113,156,000 NO Shortfall	
Maine	$6,706,126	$9,888,891	$9,474,940	$12,462,201	$40,331,747	$23,091,000 NO Shortfall	
Maryland	$65,846,887	$33,845,564	$38,121,348	$48,348,857	$183,767,756	$117,677,000 NO Shortfall	
Massachusetts	$27,707,902	$46,201,047	$46,201,047	$59,401,346	$179,511,342	$89,476,000 NO Shortfall	
Michigan	$0	$86,598,091	$89,136,280	$111,345,887	$287,081,828	$188,252,000 NO Shortfall	
Minnesota	$0	$0	$23,164,277	$36,814,569	$63,778,896	$61,445,000	$17,667,134
Mississippi	$13,804,712	$0	$36,887,325	$48,155,511	$98,887,548	$120,815,000	$22,247,451
Missouri	$0	$20,239,122	$41,923,481	$53,968,180	$116,130,783	$93,386,000 NO Shortfall	
Montana	$0	$10,006,270	$10,193,881	$12,284,292	$32,483,443	$18,148,000 NO Shortfall	
Nebraska	$0	$0	$12,462,163	$17,068,147	$29,578,310	$28,354,000 NO Shortfall	
Nevada	$0	$30,436,453	$31,163,967	$40,387,249	$101,987,669	$27,629,000 NO Shortfall	
New Hampshire	$3,143,900	$8,903,739	$8,013,396	$9,272,809	$29,333,814	$7,845,000 NO Shortfall	
New Jersey	$0	$0	$25,767,757	$94,735,099	$110,502,856	$242,284,000	$131,781,144
New Mexico	$25,383,498	$32,788,606	$32,788,606	$42,158,779	$133,117,489	$75,701,000 NO Shortfall	
New York	$164,030,940	$227,517,050	$216,456,790	$270,142,080	$878,145,860	$511,825,000 NO Shortfall	
North Carolina	$40,464,013	$47,513,855	$85,763,907	$110,258,024	$303,999,799	$201,153,000 NO Shortfall	
North Dakota	$0	$5,438,865	$5,438,865	$6,364,719	$17,258,109	$5,550,000 NO Shortfall	
Ohio	$0	$60,480,850	$103,803,316	$125,842,184	$290,126,350	$171,774,000 NO Shortfall	
Oklahoma	$0	$44,521,755	$44,521,755	$57,370,830	$146,414,342	$46,986,000 NO Shortfall	
Oregon	$1,399,872	$40,705,703	$38,068,798	$47,255,380	$127,429,753	$20,821,000 NO Shortfall	
Pennsylvania*	$0	$92,759,160	$88,747,809	$130,963,777	$322,470,746	$144,137,000 NO Shortfall	
Rhode Island	$223,863	$0	$0	$9,354,648	$9,578,509	$27,509,000	$17,930,391
South Carolina	$0	$43,402,180	$43,355,567	$54,308,115	$141,063,862	$84,520,000 NO Shortfall	
South Dakota	$0	$4,408,844	$5,790,144	$7,866,654	$18,065,642	$14,826,000 NO Shortfall	
Tennessee	$43,148,411	$56,354,612	$57,857,963	$75,954,574	$233,315,560	$17,256,000 NO Shortfall	
Texas	$0	$311,509,989	$330,851,814	$449,972,119	$1,092,327,621	$316,101,000 NO Shortfall	
Utah	$0	$24,893,700	$24,091,106	$31,899,161	$80,483,967	$30,893,000 NO Shortfall	
Vermont	$0	$3,813,158	$3,813,158	$4,902,630	$12,528,942	$2,858,000 NO Shortfall	
Virginia	$0	$53,771,771	$55,714,814	$76,254,891	$185,407,436	$63,206,000 NO Shortfall	
Washington	$25,419,796	$50,326,494	$50,326,494	$64,705,479	$190,778,212	$34,880,000 NO Shortfall	
West Virginia	$12,081,320	$18,841,332	$18,780,364	$24,422,724	$70,905,730	$32,740,000 NO Shortfall	
Wisconsin	$36,731,734	$0	$43,504,858	$51,870,414	$132,107,106	$102,853,000 NO Shortfall	
Wyoming	$0	$5,480,780	$4,952,110	$6,364,536	$16,797,395	$5,746,000 NO Shortfall	
TOTAL STATES ONLY	$733,123,920	$2,361,639,402	$3,022,698,180	$4,038,875,000	$10,177,338,502	$5,300,856,000	$236,986,934
COMMONWEALTHS AND TERRITORIES							
Puerta Rico	NA	NA	NA	NA	NA	NA	NA
Guam	NA	NA	NA	NA	NA	NA	NA
Virgin Islands	NA	NA	NA	NA	NA	NA	NA
American Samoa	NA	NA	NA	NA	NA	NA	NA
N. Mariana Islands	NA	NA	NA	NA	NA	NA	NA
TOTAL	NA	NA	NA	NA	NA	NA	NA
NATIONAL TOTAL	$733,123,920	$2,361,639,402	$3,022,698,180	$4,038,875,000	$10,177,338,502	$5,300,856,000	$236,986,934

Leavitt Confirmation

Grassley Questions for the Record

TABLE 7 - CALCULATION OF THE REDISTRIBUTION OF THE UNEXPENDED SCHIP ALLOTMENTS FOR FISCAL YEAR: 2002

Total Unexpended FY 2002 Allotments (not including MOE): $642,617,724
FY 2002 MOE Amount: $0
Total Unexpended FY 2002 Allotments (including MOE) /1: $642,617,724
Total Needed for Redistribution for Territories /2: $6,747,486
Total Needed for SHORTFALL /3: $236,986,934
Total (Territory Redistribution + SHORTFALL): $243,734,420
Total Available for Redistribution to States /4: $398,883,304

State	CALCULATION OF UNEXPENDED FY 2002 ALLOTMENTS: FY 2002 Allotment	Expenditures Applied Against FY 2002 Allotment	Unexpended FY 2002 Allotments or "REDISTRIBUTION"	Projected FY 2005 Shortfall	For Redistribution States Only FY 2002 - FY 2004 Expenditures	Redistribution States Only FY 02-04 Expenditures Minus FY 02 Allotment (Col F - B)	For Redistribution States Percent of Total Redistribution (Col G/Sum of Col G)	FY 2002 Redistributed Allotment Amounts (Col H x Amount Available for Redistribution)	FY 2005 Shortfall Amounts (Col E)	Total FY 2002 Redistribution Including FY 2005 Shortfall (Col I + J)
A	B	C	D	E	F	G	H	I	J	K
Alabama	$48,585,422	$48,585,422	REDISTRIBUTION	NO Shortfall	$196,134,364	$150,548,932	2.2599%	$8,998,424	NO Shortfall	$8,998,424
Alaska	$8,958,136	$8,958,136	REDISTRIBUTION	NO Shortfall	$84,407,963	$57,430,425	0.8607%	$3,433,196	NO Shortfall	$3,433,196
Arizona	$87,198,211	$87,198,211	REDISTRIBUTION	$47,360,814	$572,329,178	$485,192,982	7.2689%	$28,998,558	$47,360,814	$76,359,372
Arkansas	$36,291,812	$0	$36,291,812	na	NA	NA	NA	NA	na	$0
California	$528,448,580	$405,961,674	$122,486,486	na	NA	NA	NA	NA	na	$0
Colorado	$34,296,851	$29,332,734	$4,964,247	na	NA	NA	NA	NA	na	$0
Connecticut	$25,963,944	$0	$25,963,944	na	NA	NA	NA	NA	na	$0
Delaware	$8,920,206	$0	$8,920,206	na	NA	NA	NA	NA	na	$0
District of Columbia	$7,845,309	$1,816,909	$6,028,400	na	NA	NA	NA	NA	na	$0
Florida	$184,157,849	$184,157,849	REDISTRIBUTION	NO Shortfall	$894,219,752	$540,062,083	9.0910%	$36,256,995	NO Shortfall	$36,256,995
Georgia	$104,986,194	$104,986,194	REDISTRIBUTION	NO Shortfall	$590,535,951	$295,540,783	5.0270%	$20,041,771	NO Shortfall	$20,041,771
Hawaii	$9,453,752	$4,598,743	$4,855,991	na	NA	NA	NA	NA	na	$0
Idaho	$18,600,022	$8,768,455	$9,831,567	na	NA	NA	NA	NA	na	$0
Illinois	$127,220,093	$127,220,093	REDISTRIBUTION	NO Shortfall	$405,490,939	$270,230,946	4.1892%	$16,630,068	NO Shortfall	$16,630,068
Indiana	$47,030,390	$0	$47,030,390	na	NA	NA	NA	NA	na	$0
Iowa	$22,411,236	$22,411,236	REDISTRIBUTION	NO Shortfall	$86,580,475	$75,472,254	1.1489%	$4,570,903	NO Shortfall	$4,570,903
Kansas	$21,978,619	$21,978,619	REDISTRIBUTION	NO Shortfall	$112,415,516	$90,457,899	1.3552%	$5,405,542	NO Shortfall	$5,405,542
Kentucky	$36,435,991	$36,436,991	REDISTRIBUTION	NO Shortfall	$213,906,901	$174,172,410	2.6098%	$10,410,417	NO Shortfall	$10,410,417
Louisiana	$57,691,865	$57,691,865	REDISTRIBUTION	NO Shortfall	$237,884,772	$180,192,907	2.7001%	$10,770,265	NO Shortfall	$10,770,265
Maine	$9,994,099	$9,994,099	REDISTRIBUTION	NO Shortfall	$64,101,144	$54,107,045	0.8108%	$3,234,019	NO Shortfall	$3,234,019
Maryland	$32,927,307	$32,927,307	REDISTRIBUTION	NO Shortfall	$363,224,886	$329,597,579	4.9389%	$19,688,343	NO Shortfall	$19,688,343
Massachusetts	$45,516,822	$45,516,822	REDISTRIBUTION	NO Shortfall	$290,641,973	$245,125,150	3.6727%	$12,273,330	NO Shortfall	$12,273,330
Michigan	$96,923,330	$96,923,330	REDISTRIBUTION	NO Shortfall	$259,850,138	$162,964,795	2.4419%	$9,740,527	NO Shortfall	$9,740,527
Minnesota	$30,041,880	$30,041,880	REDISTRIBUTION	$17,967,134	$201,989,940	$171,822,296	2.5717%	$10,267,993	$17,967,134	$27,935,127
Mississippi	$37,917,154	$37,917,154	REDISTRIBUTION	$23,247,451	$260,297,137	$222,179,983	3.5283%	$13,291,820	$23,247,451	$36,539,271
Missouri	$45,818,456	$45,818,456	REDISTRIBUTION	NO Shortfall	$213,982,032	$168,063,577	2.5164%	$10,045,267	NO Shortfall	$10,045,267
Montana	$10,822,895	$10,822,895	REDISTRIBUTION	NO Shortfall	$58,461,167	$47,638,492	0.4129%	$1,845,399	NO Shortfall	$1,845,399
Nebraska	$14,161,451	$14,161,451	REDISTRIBUTION	NO Shortfall	$72,069,486	$57,842,036	0.9657%	$5,457,282	NO Shortfall	$5,457,282
Nevada	$27,813,589	$10,795,589	$18,850,000	na	NA	NA	NA	NA	na	$0
New Hampshire	$8,091,379	$0	$8,091,379	na	NA	NA	NA	NA	na	$0
New Jersey	$69,478,513	$69,478,513	REDISTRIBUTION	$131,781,144	$737,019,513	$667,541,000	10.0628%	$38,899,451	$131,781,144	$171,680,575
New Mexico	$53,494,842	$0	$53,494,842	na	NA	NA	NA	NA	na	$0
New York	$235,993,235	$253,993,235	REDISTRIBUTION	NO Shortfall	$1,029,982,967	$796,989,732	11.7679%	$47,019,845	NO Shortfall	$47,019,845
North Carolina	$81,129,294	$81,129,294	REDISTRIBUTION	NO Shortfall	$362,965,361	$361,884,067	4.5215%	$18,042,047	NO Shortfall	$18,042,047
North Dakota	$5,332,579	$5,181,911	$150,668	na	NA	NA	NA	NA	na	$0
Ohio	$196,125,268	$196,125,268	REDISTRIBUTION	NO Shortfall	$434,888,936	$326,643,953	4.9931%	$19,917,761	NO Shortfall	$19,917,761
Oklahoma	$46,583,004	$7,463,767	$39,119,237	na	NA	NA	NA	NA	na	$0
Oregon	$37,597,497	$0	$37,597,497	na	NA	NA	NA	NA	na	$0
Pennsylvania	$161,803,820	$161,803,820	REDISTRIBUTION	NO Shortfall	$360,830,277	$249,826,457	3.7360%	$14,902,437	NO Shortfall	$14,902,437
Rhode Island	$7,473,463	$7,473,463	REDISTRIBUTION	$17,830,391	$98,976,218	$80,961,850	1.3821%	$5,453,278	$17,830,391	$23,283,669
South Carolina	$47,903,777	$40,906,238	$6,997,539	na	NA	NA	NA	NA	na	$0
South Dakota	$5,941,727	$5,941,727	REDISTRIBUTION	NO Shortfall	$28,647,871	$22,706,044	0.3402%	$1,357,169	NO Shortfall	$1,357,169
Tennessee	$61,964,136	$0	$61,964,136	na	NA	NA	NA	NA	na	$0
Texas	$301,638,575	$197,200,669	$104,438,906	na	NA	NA	NA	NA	na	$0
Utah	$23,017,975	$22,259,217	$758,758	na	NA	NA	NA	NA	na	$0
Vermont	$5,740,345	$1,898,983	$1,841,362	na	NA	NA	NA	NA	na	$0
Virginia	$54,982,752	$35,249,201	$19,113,551	na	NA	NA	NA	NA	na	$0
Washington	$42,446,186	$0	$42,446,186	na	NA	NA	NA	NA	na	$0
West Virginia	$18,850,273	$18,850,273	REDISTRIBUTION	NO Shortfall	$84,874,656	$66,024,380	1.0198%	$4,065,669	NO Shortfall	$4,065,669
Wisconsin	$39,574,631	$39,574,631	REDISTRIBUTION	NO Shortfall	$271,870,736	$232,496,105	3.4636%	$13,896,468	NO Shortfall	$13,896,468
Wyoming	$5,297,121	$544,483	$4,752,678	na	NA	NA	NA	NA	na	$0
TOTAL STATES ONLY	$3,082,128,000	$2,498,507,276	$642,617,724	$236,986,934	$6,542,628,465	$6,672,563,643	100.0000%	$398,883,304	$236,986,934	$635,870,238
COMMONWEALTHS AND TERRITORIES										
Puerto Rico	$30,296,700	$30,296,700	REDISTRIBUTION	NA	NA	NA	NA	$6,180,687	NA	$6,180,687
Guam	$1,157,825	$1,157,825	REDISTRIBUTION	NA	NA	NA	NA	$238,162	NA	$238,162
Virgin Islands	$859,950	$859,950	REDISTRIBUTION	NA	NA	NA	NA	$175,435	NA	$175,435
American Samoa	$398,900	$398,900	REDISTRIBUTION	NA	NA	NA	NA	$80,870	NA	$80,870
N. Mariana Islands	$963,626	$963,626	REDISTRIBUTION	NA	NA	NA	NA	$74,222	NA	$74,222
TOTAL	$33,076,000	$33,076,000	$0	NA	NA	NA	$0	$6,747,486	NA	$6,747,486
								(Totals to "1.69%" Amount)		
NATIONAL TOTAL	$3,115,204,000	$2,472,582,276	$642,617,724	$236,986,934				$405,630,790	$236,986,934	$642,617,724
FY 2002 MOE AMOUNT										Total FY 2002
TOTAL WITH MOE AMOUNT	$3,115,204,000	$2,472,582,276	$642,617,724							Redistributed Allotments

Footnotes:
/1 The total unexpended FY 2002 allotments are $642,617,724, calculated as $642,617,724 (the total unexpended FY 2002 allotments, not including the maintenance of effort (MOE) amount) plus $0.000 (the MOE amount)
/2 $6,747,486 is the total amount needed for redistribution to the commonwealths and territories, calculated as 1.05 percent of $642,617,724 (the total unexpended FY 2002 allotments, including the MOE amount)
/3 $236,986,934 is the total needed for SHORTFALL
/4 $398,883,304 is the total redistribution to five states (excluding the SHORTFALL), calculated as $642,617,724 (total unexpended FY 2002 allotments including the MOE amount) reduced by $236,986,934 (the total FY 2002 SHORTFALL) and $6,747,486 (total jurisdiction redistribution)

Leavitt Confirmation
Grassley Questions for the Record

IGTs -In the letter to Senator Grassley, CMS states that "only units of local or state government are eligible to make protected IGTs." What does CMS interpret as a "unit of local or state government?"

Response:

In order for a health care provider to transfer funds that are protected under section 1903(w)(6)(A) of the Social Security Act, the health care provider must be part of a unit of state or local government. Furthermore, the IGT must be derived from state or local tax revenues. Therefore, for a governmental health care provider to make a protected transfer, it must have access to state or local tax revenues. Accessing state or local tax revenues means that the provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority (that is legally obligated to fund the governmental health care provider's expenses, liabilities and deficits) so that no contractual arrangement with the state or local government is necessary for the health care provider to receive tax revenues.

Update on status of negotiations on state's 1115 waiver applications pending and in the pre-submission stage.

Response:

CMS is currently in discussions with forty-one states on potential section 1115 waivers. States are extensively using a variety of ways to ensure broad public participation in the development of their ideas. Discussions with CMS vary but include pre-submission technical assistance, active review of submitted proposals, ongoing monitoring and oversight, technical assistance toward potential amendments to approved waivers, formal review of submitted amendments, or technical assistance and review of formal waiver renewals. CMS works with states to assist them in developing innovative solutions to the unique needs of their low-income populations. CMS provides technical assistance on an ongoing basis to states that is based on previously approved demonstrations, laws and regulations, and the specific requests by the individual state.

Just as there is wide variation in the existing waivers that have been existed for some time and are well known, such as those developed by Arizona, Oregon, Massachusetts, and Tennessee, we should expect the next generation of waivers to reflect the unique characteristics of states.

Leavitt Confirmation
Grassley Question for the Record

The *Washington Post* reported yesterday that a plan to post the results of NIH-funded research on a publicly accessible Web site within six months after they are published in a scientific journal has been "been scaled back by the [NIH] under pressure from scientific publishers, who argued that the plan would eat into their profits and harm the scientific enterprise they support." Why is it in the public interest to withhold federally funded research results from a publicly accessible website? Why is it fair to taxpayers to wait a year or more to obtain free access to published NIH-funded research? Do you agree with NIH policy that does not include a 6-month deadline and provides for only voluntary disclosure?

Answer:

I am not familiar with the details of the proposal, or of where NIH stands as it works to finalize the proposal. Nonetheless, in general, I believe that encouraging transparency and a public dialogue in managing the taxpayer's investments at NIH are critical steps to ensuring that the trust Congress has shown is maintained. If confirmed, I look forward to working with you on this and other important issues.

WAIVING THE FQHC PROSPECTIVE PAYMENT SYSTEM

Community health centers are a priority of bipartisan majorities in this Congress and with President Bush. In 2000, Congress underscored the importance of adequate Medicaid reimbursement to health centers by creating a FQHC prospective payment system (PPS), in order to ensure access to primary care services for Medicaid and uninsured patients. The PPS payment rate is intended to ensure that neither Medicaid nor Federal grant dollars we were forced to subsidize services for beneficiaries of the other.

Recently, HHS approved an 1115 HIFA waiver for the State of Utah. In addition to the apprehension I have expressed about the Utah waiver at the hearing and in the first set of written questions that I submitted, I am also concerned that this waiver could undermine the public commitment that Congress and the Administration has given these centers by waiving the PPS payment rate requirements for FQHCs that serve the expansion population.

Can the Department assure that it will not approve future waivers that waive health centers' PPS reimbursement requirements under Medicaid?

Answer:

Federally Qualified Health Centers (FQHCs) are an important part of the health care system. They provide access to health care services that many low-income families would not otherwise be able to access. Because of the paramount role of the FQHCs in our health care system, I support adequate Medicaid reimbursement to these facilities. Utah continues to pay FQHCs according to statutory rules for all Medicaid beneficiaries who are eligible under the Medicaid state plan. The PPS rate is only waived for expansion adults (those who are only eligible because of the waiver.) Prior to approval of the waiver in Utah, FQHCs did not receive any Medicaid payment for the adults newly covered under the waiver. The goal is to expand coverage and access. The federal government should be open to finding new ways to achieve both. The Utah waiver shows that the interests of both recipients and providers can be achieved. It should not be an "either/or" choice.

OUTSTATIONING ELIGIBILITY WORKERS

Medicaid law requires states to provide for the initial receipt and processing of applications for low-income pregnant women, infants and children at outreach locations other than welfare or government offices, including FQHCs and DSH hospitals. Congress specifically required states to establish outstationing locations at FQHCs because they serve substantial numbers of low-income women, infants and children, and we wanted to ensure that if these women and children were eligible, they would receive the benefits of Medicaid.

However, according to a recent report, 17 states, including Montana, are non-compliant with this statutory requirement, and many others are only partially compliant.

Leavitt Confirmation
Baucus Questions for the Record

In light of the Administration's proposal to expand care to more low-income children under SCHIP, can you assure me that the Department will seek to ensure that states comply with the outstationing law so that those already eligible can be covered?

Answer:

- Consistent with the requirements of federal Medicaid law, states have flexibility when implementing outstationing. To assist states in implementation of the outstationing provision, we issued regulations and detailed guidance.
- One option allowed by the regulation is not to have outstations at every FQHC site depending on the frequency that the FQHC treats unenrolled pregnant women, infants and children.
- In situations where the FQHC sees few target individuals, states use alternative means to assure that these individuals are given the opportunity to enroll in Medicaid.
- Within the constraints of our resources and other priorities, we seek to ensure that states are complying with statutory requirements.
- The report mentioned in question is not identified so we are unable to comment on the allegations of noncompliance. But, we would be glad to look into the allegations of state noncompliance.

WELDON AMENDMENT

The recently enacted Federal Refusal Clause, which was included in the Omnibus appropriations bill that passed last November, allows health care companies to refuse to ensure women access to abortion services and information, presents a conflict with a number of other federal - not to mention state and local - laws. For example, the federal government currently requires that Title X-funded clinics refer clients to abortion providers upon request. The Federal Refusal Clause makes that requirement unenforceable. The law also interferes with states' ability to comply with the federal Hyde amendment, which ensures that Medicaid clients have access to abortion services in cases of rape, incest, or when the pregnancy endangers a woman's life.

I am concerned that this law effectively sanctions health-care companies to gag doctors as to sound treatment options for their patients. Is this an approach you would support? Are there other situations where you would sanction interference in what a doctor may communicate to his or her patient? How would you recommend reconciling these competing laws as they affect programs under your jurisdiction?

Answer:

The Weldon Conscience Protection Amendment to the Labor, Health and Human Services, Education funding bill (enacted in the fiscal year 2005 Omnibus Appropriations bill) prohibits discrimination against health care entities who decline to provide, pay for, provide coverage of, or refer for abortions. It bars funds under the HHS funding bill from being made available to any Federal agency or program, or any State or local government, if that agency, program or government subjects a health care entity to such discrimination. It also clarifies existing law to state that a "health care entity" includes a hospital, a health professional, a provider-

sponsored organization, a health maintenance organization, a health insurance plan or any other kind of health care facility.

Consistent with the Hyde Amendment that has been in place for nearly 30 years, the Weldon amendment recognizes that government can distinguish between abortion and "other medical procedures, because no other procedure involves the purposeful termination of a potential life." (Harris v. McRae, 448 U.S. 297 (1980) at 325) The Weldon language, far from restricting the rights of hospitals and physicians, prohibits Federal programs and agencies from violating the rights of health care professionals, or the institutional standards of health care entities, by forcing them to provide, pay for or refer for abortion. Several similar protections already exist under federal law and most states protect the rights of health care providers that decline to participate in abortions.

As Secretary of HHS, I will certainly carry out the laws enacted by Congress as they apply to the programs under the Department's jurisdiction. To the extent that any HHS offices or agencies may be in the position of requiring participation in any of the listed abortion-related activities, I will review those program requirements and implement the law appropriately.

LANGUAGE ACCESS ISSUES

Under a Presidential Executive Order issued by President Clinton in 2000 and affirmed by President Bush after he took office, states are now eligible for federal funding matches in their Medicaid and SCHIP programs for language access services they provide for limited English proficient individuals, but only about 9 states are providing this service and CMS has not yet issued an agency plan for implementing this order. Utah was a pioneer in this area, and has drawn down a federal match in Medicaid and SCHIP to help pay for language services since 2001. The state contracts with five language service organizations (covering 27 languages) to provide in-person and telephonic interpreter services to fee-for-service Medicaid, SCHIP and medically indigent program patients.

Unfortunately, few other states are now using federal reimbursement and many states do not know that they have this option. What will you do to ensure that CMS implements this order, and to make sure that all states know of the availability of Medicaid and SCHIP reimbursements for language services and use it to improve access to non-English speaking individuals?

Answer:

On August 30, 2000, shortly after President Clinton issued Executive Order 13166, CMS (then HCFA) sent a letter to all State Medicaid Directors emphasizing that under both the Medicaid and SCHIP programs, Federal matching funds are available to states for administrative and service expenditures related to the provision of language access services for limited English proficient (LEP) Medicaid and SCHIP applicants and recipients. Senior-level CMS representatives have reiterated this policy, and have shared the Department's August 8, 2003 revised LEP guidance, in several Diversity Open Door Forums and, more recently, in a meeting with the Health Coalition.

Leavitt Confirmation
Baucus Questions for the Record

MENTAL HEALTH PARITY

As Governor of Utah, you signed into law the Utah Catastrophic Mental Health Parity Act, which went into effect in 2001. Analysis by the Utah Department of Insurance has indicated that, as a result of the law:

- **mental health coverage has increased from 80% to 93%,**
- **few employers terminated mental health coverage despite having that option, and**
- **the cost of the law represented a 0.9% increase of total claims, exactly as predicted by the actuarial analysis by proponents of the bill.**

Given those favorable results, isn't it likely that federal parity legislation would have the same effect? Are you supportive of extending the current federal mental health parity legislation and ensuring greater access to mental health services for privately insured individuals?

Answer:

I believe that parity between mental health and "physical" health services in health insurance is a laudable and appropriate goal. I share the President's and Secretary Thompson's commitment to working with Congress to address the concerns of patients. That said, given that there is not always a logical "apples to apples" way to compare mental health versus physical health services, I believe it will take an investment of time and energy to try and identify the right policy to address patients' concerns. I will certainly work with the Congress as legislation is considered by the Committee.

POWER WHEELCHAIRS

Concerns have been raised that the current national coverage criteria for power wheelchairs continue to be inconsistently interpreted by CMS contractors, leaving many Medicare beneficiaries with limited access to manual and power wheelchairs. CMS's December 2003 "clarification," stating that only those beneficiaries who would be otherwise considered "bed or chair confined," was retracted in March 2004. In December 2004, CMS released recommendations from its Interagency Wheelchair Work Group (IWWG) comprised of clinicians, physicians, researchers and policy specialists, to cease applying its "bed or chair confined" standard and adopt a new functionally based clinical criteria for mobility device prescribing.

What will you do to ensure that CMS quickly finalizes and implements the new national coverage policy for mobility assist devices? Will it be based on a functional standard as outlined in the IWWG's recommendations and the current standards of medical practice?

Answer:

On December 15, 2004, CMS opened an NCD on mobility assistance devices to examine and set the clinical criteria for the provision of wheelchairs. Based on the recommendations of the federal workgroup of clinicians who have practical experience prescribing wheelchairs -the

Interagency Wheelchair Work Group (IWWG), CMS proposed to replace the historical "bed or chair confined" standard with function-based clinical criteria for mobility assistance device (MAD) prescribing. The MMA-required NCD process specifies a proposed decision no later than 6 months after the NCD opens and a final decision posted no later than 9 months after the NCD is initiated.

CMS initiated a national coding project in early 2004 to determine proper pricing for Medicare reimbursed power wheelchairs. Since that time CMS has encountered significant problems when using its "gap-filling methodology" to determine appropriate Medicare pricing for DMEPOS. Will you commit to ensuring that CMS works with all interested stakeholders this year to develop an improved methodology for determining appropriate payment for new DMEPOS codes?

Answer:

The current method used by CMS to determine payment amounts for new DMEPOS codes is the same method that has been in place since 1989. CMS understands that this method can be revised to produce payment amounts that better reflect the true costs of furnishing items. I will work with CMS on this important issue.

Some argue that current law does not limit Medicare coverage of medically necessary DME that would enable a beneficiary to leave the home to go to work, attend school or attend religious services, among other activities. Are you willing to review the "in the home" policy as it relates to DME and, if necessary, recommend alternatives to it?

Answer:

Section 1861(n) of Title 18 of the Social Security Act states that the power wheelchair is for use in a patient's home. The "in home" restriction means that for DME, such as a wheelchair, to be covered, a beneficiary must have a medical need to use the DME in the home. This requirement excludes DME from coverage if there is only a medical need to use the equipment outside of the home. However, if DME is medically necessary in the home and the beneficiary also uses it outside of the home, the equipment would still be covered.

HOSPITAL OUTPATIENT SERVICES

In many cases, patient care can be provided more efficiently through hospital outpatient services, avoiding costly overnight hospital stays. However, the current formula used to determine Medicare reimbursement for procedures performed in an outpatient setting sometimes results in inadequate reimbursement for procedures using advanced medical technologies, providing an incentive to perform certain procedures in the more costly inpatient setting.

As Secretary of HHS, what will you do to ensure that Medicare patients have access to high-tech medical devices in the outpatient setting?

Answer:

CMS will continue to expedite review of applications for pass-through status for new medical devices and special payment for new technology services to ensure timely disposition and integration into the hospital outpatient prospective payment system. CMS will continue to assign temporary codes to minimize the time lag between the launch of new advanced technology products and services following FDA approval and their integration into CMS claims processing modules.

Moreover, I believe that the federal government can play a critical role in encouraging and facilitating the adoption and use of health information technology. And I am very confident that the use of health information technology nationally can and will move our health care industry forward, simultaneously improving efficiency and productivity and reducing overall health care costs.

LONG TERM CARE PHARMACY

Part D was designed for an "ambulatory" population, and not with nursing home beneficiaries in mind. Nursing home residents often cannot get up and go to an "in network" pharmacy to get their drugs. Instead, a LTC pharmacy services the nursing home, consistent with standards of care and federal and state regulations that have evolved over the years. Services provided include 24-hour, 7-day delivery, IVs, "stat" or emergency delivery, and drug reviews. The MMA regulations so far do not ensure that PDPs reimburse LTC pharmacies for these specialized pharmacy services.

What assurances can you provide that CMS will adequately review PDP applications to ensure that PDPs are committed to providing, and paying for, these services?

Answer:

The final rule requires Part D plans to provide convenient access to covered Part D drugs for beneficiaries residing in long term care facilities. CMS recognizes the specialized pharmacy services that LTC residents require.

OUTPATIENT LABS

As you know, many areas of the U.S. are experiencing severe personnel shortages in the area of clinical laboratory science, as well as in nursing and other allied health care professions. As Secretary, what will you to do ensure access to these services and address what I understand to be a growing problem of workforce shortages?

Answer:

I understand your concern about a limited number of clinical laboratory personnel, as these health care professionals are now more in demand. HHS, through the Health Resources and Services Administration, administers an allied health program that focuses on addressing this issue by providing grants to train allied health professionals, including clinical laboratory professionals, and place them in medically underserved communities.

There continues to be a serious shortage of nurses across the U.S. and a shortage of nursing faculty that is limiting the number of students that can be admitted to schools of nursing. HHS administers several programs that specifically focus on alleviating this nursing shortage, including a nurse faculty loan program to increase the number of qualified nursing faculty. Funding for these activities has increased by 75 percent since FY 2001.

By continuing to focus on the problem of maldistribution of health care professionals across the country, we will help ensure access to health care for those in need. As you are aware, HHS administers a successful program that specifically addresses this issue – the National Health Service Corps (NHSC). This program provides financial incentives, through scholarships and loan repayments, to primary care health professions students and providers who agree to serve in underserved areas. This program has supported more than 24,500 health professionals committed to service to the underserved, and approximately 6 million people now have access to care from NHSC clinicians. HHS also continues to expand the Community Health Center program to ensure that affordable health care is available in underserved areas across the country.

The Department's efforts to ensure an adequate supply of health care providers are guided by studies carried out by the National Center for Workforce Analysis. This center continues to conduct studies that help develop strategies to meet the health workforce needs of an increasingly diverse and aged population.

REGULATORY BURDEN

I hear many complaints from Montanans doing business with HHS/CMS about shifting positions and policies from the federal government – despite inclusion of the regulatory relief provisions included in the 2003 Medicare law (MMA). Providers tell me this fosters resentment and distrust of HHS and CMS. What can we do beyond the MMA provision to restore the trust of those in my state (and others) who feel this way?

Answer:

CMS strives to maintain an open and transparent regulatory process, while following the requirements of the Administrative Procedures Act. CMS holds regular nationwide conference calls, known as Open Door Calls, to respond to concerns and give information on policy initiatives . CMS staff regularly interacts with public sector individuals, members of Congress and their staff, and various trade and professional associations; and the CMS Website provides information including data and background discussion used in formulating our regulations, as well as frequently asked questions, manuals and training modules. CMS regional office staff also engage in outreach and education activities, visiting numerous provider and beneficiary entities over the course of any given year to provide them with information needed to participate in the Medicare, Medicaid and SCHIP programs. Although the Medicare, Medicaid and SCHIP programs are substantial, CMS works to be open and transparent with the public to meet their informational needs, and I hope to work with CMS to continue this process and reduce the feeling of confusion that may exist among some stakeholders.

Leavitt Confirmation
Baucus Questions for the Record

REIMPORTATION

As you know, there is a great deal of interest in Congress regarding reimportation of prescription drugs. Many argue that such a measure would greatly reduce American consumers' drug costs, and that safety of those imported drugs can be ensured. What is your position on reimportation legislation that was introduced in the Senate last year, specifically, S. 2307, S. 2328 and S. 2328?

Answer:

I have not had the opportunity to review the specifics of each bill introduced on this topic last year. However, as you know, the HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to work to make prescription drugs affordable.

INDIAN HEALTH

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to many entities, including tribes in Montana. My constituents tell me that the Indian Health Service is inadequately funded to respond to the need for a wide range of services, including adolescent drug abuse prevention, intervention and treatment. Many tribes have a high incidence of mental and substance abuse problems, particularly related to methamphetamine, and are often unable to access federal programs for help.

In your opinion, what can be done to provide the Tribes with adequate funding to provide appropriate prevention, intervention and treatment programs?

Answer:

Alcohol and substance abuse have and continue to be among the most pervasive health and public health concerns in Indian Country. These problems are complex, highly resistant to

change, and require coordinated efforts. However, it is important to understand that virtually all Alcohol and Substance Abuse funding - 97% of the IHS Alcohol and Substance Abuse budget, for example - goes directly to tribes and tribal programs. It is the tribes and tribal communities themselves that now control and direct their own resources to address these problems

At the federal level, to directly support the tribes with these issues, the Department of Health and Human Services (DHHS) and the Indian Health Service (IHS) convened the IHS National Tribal Consultation on Alcohol and Substance Abuse, which finished its two-year work during fiscal 2003. It represented the first alcohol consultation in 17 years. It resulted in the development of a Five Year Strategic Plan for Alcohol and Substance Abuse as well as a National Fund Distribution Formula for increased monies from the Omnibus Spending Bill of 2001 (approximately $15 million directly to Alaska and $15 million to the lower 48). Approximately 150 tribal leaders and representatives collaborated to develop a monumental document for the positive future of alcohol and substance abuse.

In the area of alcohol and substance abuse, IHS has collaborated with other HHS agencies, leading to shared initiatives, staff, and programming among SAMHSA, including CSAT and CSAP, as well as CDC and NIH. Over the last three years HHS agencies have begun working more closely and effectively to support tribes and tribal programs to address the epidemic problems associated with alcohol and substance abuse. Currently, IHS is working on coordinated research; data collection; service delivery including critical partnerships with researchers; other DHHS agencies and Operating Divisions; and even the Canadian government, under a formal MOA, to address the complex nature of alcohol and substance abuse in Indian Country.

This is a critical issue and one that HHS will continue to address under my leadership.

NATIONAL RURAL HEALTH INITIATIVE

In 2001, outgoing HHS Secretary Thompson charged "all HHS agencies and staff offices to examine ways to improve and enhance health care and human services for rural Americans. In 2002, as part of the HHS Rural Initiative, Sec Thompson expanded the National Advisory Committee on Rural Health to include 'human service issues.' Do you intend to maintain the national Rural Health Initiative developed and implemented by Secretary Thompson?

Answer:

I appreciate and share your interest in ensuring access to quality health care in rural communities. Secretary Thompson has made great strides in this area. I fully support these activities and look forward to the opportunity to continue moving HHS forward in expanding access to health and human services in rural areas. In doing so, I will consider the contributions of the National Advisory Committee on Rural Health and Human Services and the HHS Rural Task Force.

Leavitt Confirmation
Baucus Questions for the Record

MEDICAID

According to CBO data, Medicaid cost growth per person has been lower than that of Medicare -- 4.5 percent on average, compared to 7.1 percent for Medicare and over 10 percent for private insurance. Does your data suggest that Medicaid cost growth is faster than that of other health programs?

Answer:

For the period 1970-2003, Medicare costs per enrollee grew 9.2 percent on average,. For the same period Medicaid spending, on a per enrollee basis, was 7.3 percent.

Comparisons between Medicaid and other payers on a per capita basis should be done with some caution. For example, the vast majority of Medicaid recipients are children while Medicare obviously covers elderly and disabled individuals.

At the aggregate level, in 2003, growth in the Medicaid program was 7.1 percent, Medicare grew 5.7 percent and private health insurance grew 9.3 percent. SCHIP grew 17.4 percent in 2003. Spending growth in other federal health programs ranged from -2.2 percent growth in the Department of Defense to 10.3 percent growth for the Veterans Administration, all other Federal programs grew 10.1 percent. State and local programs, excluding Medicaid and SCHIP, grew 6.4 percent in 2003.

Medicaid differs from Medicare and private health insurance in important ways. Medicaid is in many respects 51 state programs with the choices of individual states around optional benefits offered and optional populations covered having an impact on Medicaid spending growth. Moreover, as a means-tested program, Medicaid rates of growth also can depend on overall economic growth, as economic growth impacts the number of people eligible for the program.

In 1997, you said that you opposed per capita spending caps for Medicaid, saying that you believed it was "critically important [that] the level of Medicaid savings not be set arbitrarily to fill a hole in a deficit-reduction package." Yet, in 2002 you praised a Bush Administration FY 2003 budget proposal that would have offered States 10-year capped allotments for Medicaid. What will be your position going forward on the issue of spending caps for Medicaid?

Answer:

We need to discuss both the Medicaid program in terms of how it is designed to deliver health insurance coverage and long term care services and Medicaid financing. We can improve service delivery for individuals who rely on Medicaid and still reduce the rate of growth compared to budget baselines.

It is clear when you talk to any governor or state legislator, republican or democrat, that the rate of growth in Medicaid is unsustainable. Medicaid is crowding out other obligations of states, including

education and public safety. The risk of doing nothing is greater than finding sound ways to slow the rate of growth.

In developing ways to slow the rate of growth for both financing partners and to avoid unfair cost shifts from one to the other, we should not rule out any approach as we begin the dialogue. Delivering health care to the needy is important, but Medicaid is flawed and inefficient. We can do better. We can expand access to medical insurance to more people by creating flexibility for our state partners and transforming the way we deliver it, and I look forward to working with the committee on this important issue

As Governor of Utah, you implemented a waiver to the Medicaid program that paid for an expansion of coverage for low-income childless adults by curtailing benefits for some prior Medicaid recipients, including low-income former welfare recipients and medically needy parents. What criteria will you apply in determining whether section 1115 waivers should be approved by HHS? Additionally, I have been seeking, along with Senator Grassley, answers to the following questions regarding 1115 waivers for quite some time:

- **What States are currently working with CMS to negotiate 1115 waivers? (While the CMS website is somewhat helpful, it does not include waivers that have not yet been filed.)**

Answer:

CMS is currently in discussions with the following forty-one (41) states and the District of Columbia: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

- **What factors does CMS use to evaluate 1115 waiver applications?**

Answer:

Section 1115 waiver projects are evaluated to ensure that the project is likely to assist in promoting the objectives of title XIX or title XXI. CMS encourages state innovation and flexibility in the design of a waiver project so that the project is tailored to the needs of each state's low-income populations. Taking into consideration the unique state environment, CMS considers many factors when evaluating 1115 waiver applications, such as previously approved demonstrations; statutory provisions and regulations; and beneficiary access to care and quality assurance. Furthermore, section 1115 waiver projects must not cost the federal government more than the Medicaid program would have cost without the project. When a state submits a section 1115 waiver application, it must show that it has adhered to the requirements for public input that are described in the Federal Register, Vol. 59, No. 186 dated September 1994 and, if applicable to the waiver, consulted with Native American/Alaska Native Tribes.

- **What is the Administration's "bottom line" in approving waivers? For example, if a State wanted to place time-limits on Medicaid benefits, is that something the Administration would support, or even encourage?**

Answer:

States have taken vastly different approaches in their design of their waivers, so it would be difficult to lay out specifics to apply to all waivers.

Each state's waiver application is reviewed within the context of the specific needs of the population in the state by the federal review team which consists of federal partners from within the Department of Health and Human Services and the Office of Management and Budget.

Limiting the time that certain beneficiaries can receive Medicaid is already incorporated into Medicaid law and is not new. Transitional Medicaid Assistance (TMA) is a mandatory Medicaid eligibility group authorized under section 1925. TMA for families who lose section 1931 eligibility due to income may receive up to 12 months of coverage. (If section 1931 were to sunset, the time limit will be four (4) months under 1902(e)(1).) TMA for families who lose section 1931 eligibility due to child support payments may be eligible for 4 calendar months. Furthermore, states have routinely in their 1115 waivers, that provide only family planning benefits, restricted eligibility for a limited duration. If a state wanted to extend eligibility for a 1931 group, it certainly would receive serious consideration. We have not adopted a specific policy on time limits for expansion populations.

A 2002 GAO report on Medicaid and SCHIP waivers raised concerns about the degree of public input that was permitted and the accuracy of the budget neutrality estimates in the Utah Medicaid waiver. In fact, I have raised concerns about the transparency of the waiver process and its openness to the public since the GAO report was released in 2002. I know Chairman Grassley has shared these concerns, and we have both raised questions about whether these waivers permit States to inappropriately spend federal funds for programs that fail to meet statutory requirements, including the budget neutrality rules. What will you do to ensure that future Medicaid waivers will not be subject to criticism along these lines? Can you assure members of this committee that transparency and broad consultation will be required when States submit waiver proposals involving major program restructuring?

Answer:

While I have not yet had a chance to read the 2002 GAO report on Medicaid and SCHIP waivers, I agree with you on the need for transparency and broad consultation on waiver proposals and understand that the Department provides ample opportunity for public input at both the state and federal level. As you know I strongly believe in the ability of the 1115 waivers to provide states much-needed flexibility to address the needs of individual states.

Some States have sought additional flexibility on the amount of cost-sharing they can impose, but numerous studies have demonstrated that increasing cost-sharing can erode access and

could actually increase overall health costs. A recent Harris poll found that patients facing greater cost-sharing are less likely to seek needed treatment - less likely to visit a doctor when they have a medical problem, fill prescriptions or take the appropriate dosage, follow up on doctor referrals, or get an annual check-up. While increasing cost-sharing might appear to save money in the short run, it could actually drive up costs in the long run. How would you ensure that any increases did not unduly impede access or increase program costs over the long term? Further, at least three federal court cases now pending indicate that Medicaid's cost-sharing provisions cannot be waived. What steps would you take to ensure that current and future waivers do not violate the requirements of federal law?

Answer:

Medicaid is designed to protect and assure access to health care for our most vulnerable citizens and populations. I strongly believe in Medicaid and these important safeguards. You may be assured that, as Secretary, I intend to protect our most vulnerable populations, but I also believe we must seek innovative ways to assure that health resources are made available to as many individuals as possible within the guidelines of the program including the use of waivers.

Last week, Florida Governor Jeb Bush announced a new Medicaid waiver proposal that appears to replace Medicaid's minimum federal benefit with a risk-adjusted premium to pay for an individual's care up to a capped amount. Although details are limited, the proposal presents a number of concerns about the scope of changes that can be made by waivers. For example, it is unclear whether the proposal seeks a waiver of EPSDT requirements, which ensure that children covered by Medicaid have access to medically needed treatment once a medical condition is diagnosed. Would you support waiver requests from States that propose to narrow or eliminate the EPSDT benefit? The proposal also appears to impose an upper limit on the benefits that Medicaid would provide, even for a disabled individual or someone with HIV/AIDS. Would you support these types of limits on the benefits provided to children and chronically ill and disabled individuals? If so, how would you envision that States could respond to the unmet medical needs for these populations?

Answer:

In general, I believe that EPSDT is a very important benefit that must be preserved and protected for the most vulnerable children—those with disabilities and those in families at the lowest income levels.

I understand that there are existing waivers that do not provide EPSDT coverage for all children covered by the waiver. The Oregon health plan, for example, does not. Twenty-one states have approval for family planning services only and children are included in a number of these waivers, so I would hesitate to make a blanket statement to cover all situations.

One justification for offering narrower benefits to Medicaid expansion groups has been that newly covered individuals would be able to find charity care for urgent medical needs. This rationale was also offered in Utah when the State adopted its Medicaid waiver. However, data reported by the Primary Care Network of Utah suggests that nearly two-thirds of those who

were referred for specialty care in 2002 did not ultimately receive any treatment. Has this data changed your view on whether providing beneficiaries with stripped-down benefits will ensure access to medically necessary care?

Answer:

Without the waiver, individuals would not have had access to the care they received. Clearly the design of the waiver focused on preventive and basic care. Nonetheless, progress is also being made to expand access to specialists as well. The Utah Department of Health reports that:

- Almost 600 PCN enrollees were able to access needed specialty care in the first half of 2004;
- Only 37 percent of PCN enrollees visited a specialist in the six months *before* enrollment in the PCN, but 44 percent of PCN enrollees received specialty care within the first year *after* being enrolled in the PCN; and
- The percentage of PCN enrollees who did not receive needed specialty care *declined* from 63 percent in 2002 to 56 percent in 2003.

The Utah Department of Health is preparing a second response to this issue based on a review of their PCN claims data.

The Primary Care Network provided access to health care to 100 percent of those individuals who would not otherwise have had access to any care, other than charity care. In Utah, the hospitals agreed to provide $10 million of services to Primary Care Network enrollees and the enrollees had access to primary services that prevent more substantial health care issues in the future. I think that providing these benefits to a population that otherwise would have had nothing is good public policy and has provided important services to a population in Utah in great need of these benefits.

It is my understanding that the actual rebates States receive, on average, through the Medicaid rebate program is between 18-20 percent. Given that States' purchasing power will be severely diminished once the Medicare drug benefit goes into effect in 2006, would the Administration support increasing the minimum rebate from the current 15.1 percent to something that more closely represents the rebates that States are actually receiving - like 20 percent? What other changes would you propose to address the rising costs of prescription drugs in Medicaid?

Answer:

I understand your concern with the Medicaid prescription drug program and the associated rebates. Final decisions on the FY 2006 President's Budget have not been made.

For some time now, the Finance Committee has requested more detail on the new rules that CMS is applying to States seeking approval for their IGT arrangements. States tell us that programs they have had in place for years are now subject to enhanced review, additional questions, and new standards for approval. But none of these new standards or rules have ever been made public. What changes has CMS implemented for IGT arrangements? When will these changes be made public and in what form?

Answer:

It is my understanding that CMS has not made any changes for IGT arrangements but is enforcing existing rules.

The current funding formula for determining the federal funding match rate known as the FMAP has been criticized as failing to respond quickly enough to sudden economic downturn or disasters that prompt increases in Medicaid enrollment. It also fluctuates greatly from year to year, causing major disruptions in state budgets. Some have suggested that changes, for example updating the data on which the FMAP formula is based and adding a contingency fund, are needed to make FMAP more fair and more stable for States. Do you support these types of changes to the FMAP?

Answer:

We should explore methods for greater stability and predictability in federal funding. Having said this, it is my understanding that this issue has been reviewed for many years and from the various GAO reports, these studies have all concluded that to add new adjustment factors would have significant redistribution impacts. In general, more states would be negatively impacted than positively impacted.

Currently, 21 States have expanded access to Medicaid family planning services to low-income women who would not otherwise be eligible for Medicaid. These programs have been extremely successful in increasing access to family planning and helping women avoid unintended pregnancy - at considerable savings to state and federal governments, according to a recent CMS-funded study of expansion programs in six States. Will you support state efforts to initiate these Medicaid family planning eligibility expansions?

Answer:

Family planning waivers are interesting examples of narrowly defined benefit packages, many of which provide coverage for only a limited time.

The ability of these programs to provide family planning services while remaining budget neutral and not supplanting other public funding sources, such as the Title X Family Planning Program of the Public Health Act, the Title XX Social Services Block Grant (SBBG) of the Social Security Act, and Title V Maternal and Child Health Block (MCH) Grant of the Social Security Act continues to be approved by CMS.

Current law requires legal immigrant women who are pregnant to have been in this country five years before they are eligible for coverage under Medicaid. This is not only unfair, but imprudent as a matter of health policy, since these children will be U.S. citizens when they are born and eligible for Medicaid coverage. Do you support expanding coverage to pregnant women who are legal immigrants?

Answer:

I recognize that extending coverage would be a cost shift from private individuals to the public which should not be encouraged as public policy. The restrictions in Medicaid are based on the legal obligations of the sponsor who brings an individual into the United States to provide for the needs of the person voluntarily seeking entry.

The restrictions on public benefits, including Medicaid, to non-citizens were signed into law by President Clinton therefore Congress would have to change the law. Medicaid does provide coverage for emergency services.

I recognize that this is an important issue to and, as Secretary, would be happy to discuss this with you.

SCHIP

Outgoing HHS Secretary Tommy Thompson proposed reauthorizing the SCHIP program in 2005, two years before it expires. What is the policy rationale for early reauthorization? Will the Administration continue to push for early reauthorization of SCHIP in the context of Medicaid reform? What is the likelihood for success, given how difficult it has been to reauthorize TANF since it expired in 2002 and has been subject to numerous short-term extensions of current law?

Answer:

I am aware that Secretary Thompson has discussed reauthorizing SCHIP in 2005, and I understand that this idea has some support in the Senate. However, I am not in a position at this time to support or oppose such a move. If confirmed as Secretary, I will make SCHIP a priority issue and intend to work closely with the committee on this important program.

This coming year, the Secretary of HHS will have discretion to redistribute unspent FY2002 SCHIP funds to the States that have spent their FY2002 allotments. What are your priorities in disseminating these funds? When will the final advisory guidance on rules for distribution be released?

Answer:

This has been confirmed – it did go in the FR todayOn Tuesday, January 18, CMS put the notice for the redistribution of the FY 2002 SCHIP funds on display at the Federal Register. Under the FY 2002 redistribution methodology contained in the notice, our first priority was to provide for the projected shortfalls in available SCHIP funding in FY 2005 for 5 states (Arizona, Minnesota, Mississippi, New Jersey, and Rhode Island). After the shortfall states are made whole, 28 redistribution states (including the 5 shortfall states) will receive the remaining redistribution funds based on the same redistribution allocation formula used in previous fiscal years.

Last year, the President proposed providing an additional $1 billion in federal funds for state outreach and enrollment to increase the number of children covered under the SCHIP program. While I fully support expanding enrollment under SCHIP, I am concerned that this proposal would not increase SCHIP enrollment. Today, many States have more federal funds than they need to cover all eligible children, but cannot spend their federal dollars because they lack the state matching funds to provide the coverage. A growing number States that would like to cover more children are now facing shortfalls in federal funds – this year, 6 States will face shortfalls and as many as 18 will be in shortfall by 2007. Given that the problem appears to be that States do not have enough funds to provide coverage, won't giving more money for outreach only exacerbate the problem States now face and create an even wider gap between demand and coverage?

Answer:

As Secretary it will be one of my highest priorities to work with Congress to increase access to quality, affordable health insurance coverage for all Americans. This focus should start, as the President said last summer, with finding and enrolling children who are already eligible for Medicaid and SCHIP.

The State Children's Health Insurance Program has made significant progress in reducing the rate of un-insurance and providing health care access to children. However, there remain many eligible children who are not enrolled. I believe that the President's proposal to designate $1 billion for outreach, coupled with joint collaboration efforts will improve the enrollment of underserved children in Medicaid and SCHIP.

MEDICARE

For some time now, the Finance Committee has sought a full accounting from HHS of the $1 billion in administrative funding provided under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) for implementation of the new program. We have yet to receive anything. Please provide a detailed breakdown of how the $1 billion has been spent to date - or will be spent in the future.

Answer:

One of the leading priorities of mine as Secretary will be to effectively implement the landmark Medicare Modernization Act. As you noted, Congress recognized the resource needs that this sweeping legislation would demand, and provided $1 billion to fulfill these obligations. CMS has a very robust plan to spend the $1 billion MMA implementation appropriation. The prime directive in allocating these funds will be to ensure that the new benefits and programs that the MMA made available for our beneficiaries are implemented on time and efficiently.

These are a few of the major priorities:

- Enhancing Beneficiary and Provider Outreach - $436 million, 44 Percent. The only way that the MMA will be successful is if we are successful in educating our beneficiaries, providers and other partners about how the MMA will impact them.

  Our investments in this area include: enhancing the functionality and availability of 1-800-MEDICARE, creating new functionality for our web sites, expanding our capacity - through local partnerships - to interact on a 1:1 basis with our beneficiaries and creating an information sharing network to ensure that employers, providers and plans understand the implications of the MMA.

- Staffing CMS to Meet the Mandates of MMA -- $44million, or only 4.4 percent. CMS' current human capital investments are correct for the pre-MMA world. However, MMA drives us to a new way of doing business and we want a workforce that has the skills and knowledge to interact effectively in this new environment, be responsive to beneficiary needs, and provide leadership for all of our providers and partners.

  We believe that up to 500 (on a base of 4,580) new FTE will be needed who: have experience with our new business partners, are versed in cutting edge outreach and education methods, have superior analytic skills for fraud detection and are on the cutting edge of the latest information technology.

- Using Private Sector Technology and Expertise to Drive Efficient Implementation -- $276 million, 28 percent. We are making prudent investments in an information technology framework that will allow CMS to carryout its current obligations as well as implement MMA's reforms.

  Our information technology strategy: relies on investing in provide internet-based technologies to provide and process information, leverages existing technology to ensure that we are not duplicating systems, seeks voluntary partnerships with providers, plans and employers to decrease overall cost, and builds-in security and confidentially.

- Combat Fraud - $25 million, 2.5 percent. The Departments Office of Inspector General has been provided funding for this oversight role.

For several months, members of the Finance Committee have sought information from CMS on Medicare beneficiary enrollment in the drug discount card. Please provide state-by-state enrollment in the drug discount card and the transitional assistance program.

Answer:

I understand that this information has been provided to the Committee by CMS.

On January 1, 2006, more than 6 million dual eligible Medicare beneficiaries will lose their prescription drug coverage and transition to new private coverage under Part D of the new Medicare law. Under the proposed rules, beneficiaries will have only six weeks to choose or be assigned to a new drug plan - or else risk losing drug coverage. This scenario seems

unrealistic, since 38% of dual eligibles have cognitive impairments and mental illnesses, which can impair their ability to make informed choices and assimilate complex information. Dual eligibles are also twice as likely to have Alzheimer's disease as other Medicare beneficiaries. What steps will you take as Secretary to ensure that this population doesn't fall through the cracks and lose access to drug coverage? Given the severe medical need in this population - the stakes are high. What will you do to ensure they are protected?

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

The MMA requires States to continue subsidizing the pharmacy benefit for dual eligibles through the clawback mechanism. While prescription drug costs for dual eligibles will be covered by Medicare Part D, States will be responsible for making monthly payments back to HHS for a large portion of the drug expenditures for these individuals (i.e., the "clawback"). Some States have estimated that the clawback will increase state costs in FY 2006 and FY 2007. This is consistent with the CBO cost estimates for the H.R.1 conference report. In addition to concerns about the clawback mechanism itself, States report that CMS may not include rebates received in CY2004 for drugs purchased in CY2003 in its calculation of state spending in 2003, the baseline year. Can you confirm that CMS will indeed include these rebates in its calculations for a better, more accurate picture of spending in the baseline year?

Response:

I believe it is critical that we have the most accurate data on spending as we work to implement the many provisions of the MMA, and that we work to assure all costs and rebates are appropriately accounted for in order to set the accurate and correct per capita calculation. I commit to following up with you on this matter if confirmed as Secretary.

There has been significant discussion about the range of drugs that will be covered under Medicare prescription drug formularies. Many members, including me, weighed in on the draft USP model guidelines. The final guideline appears to be very similar to the draft guidelines, and I remain concerned about beneficiary access to an adequate range of drug therapies - particularly for dual eligible beneficiaries. CMS recently indicated that it will benchmark proposed Medicare formularies against commercial formularies. While these best practice examples may be helpful, the Medicare Part D benefit is a public program benefit, which differs from private, employer-sponsored coverage. As HHS Secretary, what will you do to ensure that Medicare beneficiaries have access to an adequate selection of drugs?

Response:

One of my priorities in implementing the MMA will be to ensure that any formulary that is offered is not discriminatory; and key to this process will be a vigorous review process conducted by CMS to identify formularies that do not provide a sufficient range of drugs for all Medicare beneficiaries or that discriminate against a vulnerable group of beneficiaries. As required in the MMA, formularies that discourage enrollment for certain types of beneficiaries will not be permitted.

What is the Administration's view of expanding Part D coverage to include benzodiazapines? In my view, it was an error that we did not include coverage for this entire class of drugs. In addition to depression and anxiety, these drugs are used to treat fibromyalgia and seizures, among other indications. Beneficiaries in my state have expressed concern and puzzlement about the lack of coverage for these drugs. I would like to correct this error as the bill is implemented.

Answer:

The statutory direction set by the Medicare Modernization Act (MMA) is clear. Benzodiazepines appear on a specific list of agents in section 1927(d)(3) of the Social Security act, and the MMA specifically excludes that list (with one exception) from the definition of Part D covered drugs. CMS has no authority to expand Part D coverage to include benzodiazepines.

These drugs are available generically and are fairly inexpensive. The pharmacy web site drugstore.com currently lists diazepam at $8 for 30 5 mg tabs and lorazepam at $15 for 30 1 mg tabs. The exclusion of these drugs from Medicare's drug benefit should not pose a significant hardship for most Medicare beneficiaries. For low-income beneficiaries who are dually eligible for Medicare and Medicaid, the MMA specifically gives state Medicaid programs the ability to cover these excluded drugs, including benzodiazepines, as a supplement to Medicare Part D.

As you know, many western States are sparsely populated, and pharmacies are either few or far between, or both. The MMA adopted the TRICARE standards for pharmacy access, in order to ensure appropriate access to pharmacies. The TRICARE standards stipulate that plans must have an in-network retail pharmacy within a maximum distance of specific percentages of rural, urban and suburban beneficiaries. But CMS has proposed allowing drug plans to meet these criteria on the basis of region-wide averages. This interpretation of the law presents a significant problem for places like Montana, which is grouped with 6 other States in one of the least populated PDP and MA regions. According to a joint analysis conducted by the North Carolina Rural Health Research and Policy Analysis Center and the Center for Rural Health Policy Analysis at the University of Nebraska Medical Center, the standard would allow entire swaths of this region to be without any in-network pharmacy under a multi-state prescription drug plan region. Please comment on what CMS plans to do to prevent Medicare beneficiaries in thinly-populated areas from being discriminated against when it comes to pharmacy access?

Answer:

I believe it is critical to ensure that Medicare beneficiaries in rural and thinly-populated areas have appropriate access to the new Medicare drug benefit, and intend to work with CMS to accomplish this. As you know, the TRICARE access standard provides that:

- In urban areas, at least 90 percent of beneficiaries in the plan's service area must live within 2 miles of a retail pharmacy participating in the plan's network;
- In suburban areas, at least 90 percent of beneficiaries in the plan's service area must live within 5 miles of a retail pharmacy participating in the plan's network; and
- In rural areas, at least 70 percent of beneficiaries in the plan's service area must live within 15 miles of a retail pharmacy participating in the plan's network.

This standard, however could be applied several ways – on a regional basis, to each state, or over an even smaller geographic unit such as a zip code or county. I believe it is critical that we ensure that all beneficiaries have convenient access to the new Medicare drug benefit and look forward to working further on this issue.

The MMA mandated that SSA transfer its responsibility for adjudicating Medicare appeals to HHS between July 1, 2005 and October 1, 2005. In addition to mandating this transfer, the MMA also directed both agencies to develop a plan addressing 13 specific elements related to the transfer, such as a transition timetable, workload management, and plans for hiring and training for administrative law judges who resolve appeals. In October 2004, GAO reported on its evaluation of this plan and noted that it omitted important details on how each of these 13 elements will be implemented. GAO also found that the plan overlooks the need for contingency provisions, which could prove to be essential, should critical tasks not be completed in a timely manner. What steps is HHS taking to ensure that the transfer of Medicare appeals from SSA to HHS will be completed in a smooth and timely manner? Please describe HHS's efforts to cooperate with GAO as it continues its monitoring and evaluation activities during this transition.

Answer:

Secretary Thompson and the Commissioner of SSA have continued working together to ensure a successful transition and the availability of an efficient and effective appeals process both during the transition and after the transfer of responsibility for the appeals function to HHS is complete. Throughout this ongoing process, HHS has attempted to ensure that GAO and the Congress have the most current information available regarding decisions associated with the transition and the development of the new ALJ appeals entity.

In effort to implement the transfer in an effective and efficient manner, many steps have been taken. To begin with, the Department created the Hearing and Appeals Restructuring (HAR) Team, which includes senior leadership from across the Department, to provide overall direction and guidance.

Also, on July 25, 2004, the Office of Medicare Hearings and Appeals Transition (OMHAT) was established within the Office of the Secretary/Assistant Secretary for Administration and Management. Since it was established, OMHAT has reviewed and evaluated materials provided by SSA concerning, among other things, workload, training, and processes. Building on this information, OMHAT has completed several actions that further the timely and efficient transfer of the hearings function from SSA. First, OMHAT issued three task orders: one to assess how best to employ videoconferencing and audio-conferencing technologies in the hearings process; one to assess HHS staffing needs for the ALJ hearings function and to develop a weighted workload system; and another to create a simulation of the anticipated case workflow for the Medicare hearings function. Second, OMHAT contracted with "HHS University" (an intra-Department educational network that offers HHS employees training opportunities) for a project manager to oversee the development of all training materials and the scheduling and coordination of training for all new staff associated with the hearings function, and for a complete analysis of HHS' future training needs for staff in the new ALJ appeals entity.

In addition, HHS staff members are actively working with a contractor to develop the documentation and workflow analysis for the ALJ portion of the data system.

The basics of project management involve taking actions to effect a positive outcome, as well as thinking through possible roadblocks, how to prevent them, and what arrangements would be needed if they arise. The Department is assuring that the project management process considers contingencies as one of the many inherent steps in approaching each area of this initiative.

The HHS/SSA transition plan anticipates addressing necessary contingencies. For example, the plan states that HHS will adjust the hiring of ALJs and other staff depending on actual workload volume, and will consider any possible expansion or re-alignment of the initial location of appeals offices depending on experience. Although the GAO report recommends contingencies for all of the MMA transfer plan requirements, several items in the plan, however, do not require specific contingency planning, e.g., regulations, feasibility of precedential authority, independence of ALJs, and performance standards.

The number of specialty hospitals has risen dramatically in recent years. These entities are generally for-profit, and they focus on one type of care – typically cardiac or orthopedic services. In response to concerns that the rapid growth of these facilities was harming the viability of community hospitals, which typically provide a full range of services, including emergency care, the MMA included an 18-month moratorium on the construction of new specialty facilities. This moratorium expires June 8, 2005. In the meantime, both MedPAC and HHS will report on the effects of specialty hospital growth, including the advisability of allowing physicians to refer patients to facilities in which they have a financial stake. Can you please report on the progress of the HHS study, which is due in early March? MedPAC met recently and formally recommended extending the specialty hospital moratorium until 2007. What is the Administration's position on this recommendation?

Answer:

I understand that there is great interest on the part of the Committee as to the substance of the CMS report, which as you point out, is due to be released early in March, as well as in the recent MedPAC recommendations. I assure you that, if confirmed, I will review this issue and provide a substantive response to your specific question about the Administration's position as soon as possible.

The Sustainable Growth Rate (SGR) establishes an annual spending target for physician services. Physician fees are then adjusted upward or downward, depending on whether actual spending stays within these targets. If the SGR had been left to operate, it would have reduced those rates in each of the past few years. But with the exception of 2002, Congress acted to prevent such reductions. Most recently, the MMA provided increases of 1.5 percent for each of 2004 and 2005. But after 2005, the SGR kicks in again, requiring reductions in physician payments for the next several years. Proposals to prevent cuts to the physician fee schedule are extremely costly, including one proposal from MedPAC estimated to cost about $90 billion over 10 years. How should the physician payment formula be changed? Do you believe that physician payments should be tied to improvements in quality of care, as MedPAC has suggested?

Answer:

I understand that Medicare uses a complex formula to determine the update for physicians. My understanding is that the statutory formula will result in several consecutive years of negative updates for physicians beginning in 2006. While I understand that this is a complicated issue, I haven't gotten into the details of this issue and I'm not prepared to endorse any particular solution today. I would certainly want to see if there are steps that could be taken administratively that could help deal with the issue, and I intend to work on this issue if confirmed.

Encouraging improved health care quality is a top priority of mine and of the President's. The Administration has promoted accountability for quality, creating incentives to collect data from Medicare providers on quality measures. I am intrigued by the possibility of approaches to link Medicare reimbursement to provider performance, and I look forward to further considering this issue and working with the provider and beneficiary communities and the Congress.

Prior to the MMA, numerous studies concluded that Medicare paid physicians significantly more than the cost of acquiring many Part B-covered drugs, particularly for cancer care. As a result, beneficiary cost sharing and Medicare payments for the drugs were too high - in some cases, higher than the acquisition cost. The MMA reformed the system of Part B drug payment from one based on "average wholesale price" (AWP) to one based on acquisition costs for the drug, also known as the "average sales price" (ASP). Concurrent with these changes, practice expense payments were increased dramatically. Despite these increases, I am still hearing from the oncology community that payments are not high enough to sustain access to cancer care for Medicare beneficiaries. Does CMS believe that there are widespread access problems to Medicare cancer care? If access problems are not widespread, are there local areas in particular where access problems exist? What is CMS doing to ensure continued access to cancer care under Medicare?

Answer:

I understand that the Medicare Modernization Act significantly changed payment systems for cancer care with payments under a new system taking effect on January 1, 2005. It is my understanding the CMS believes there are not widespread access problems to Medicare cancer care. It is also my understanding that it is too early to assess if there may be local areas with access problems. I believe we should monitor access to cancer care, and I intend to work on this issue if confirmed as Secretary.

Last week, MedPAC recommended cutting Medicare hospital payments in 2006 to a level of "market basket" minus 0.4 percentage points. This recommendation was made despite evidence that hospital margins under Medicare have declined in recent years, to an expected average of minus 1.5 percent in 2005. Do you support MedPAC's recommendation to reduce hospital payments in the face of negative margins?

Answer:

I recognize that hospital payment levels are extremely important to the Committee and, if confirmed, look forward to working with you on the matter. Given that the President's Budget has not yet been released, and I have had no part in compiling the HHS component, I will look forward to addressing the matter with you upon the release of the budget.

Can you outline other areas in Medicare where payment reductions may be warranted? For example, according to MedPAC, in 2004, Medicare payments to managed care plans averaged 107% of the cost to cover similar beneficiaries in traditional Medicare. Do you believe this apparent overpayment is warranted?

Answer:

Given the budgetary nature of this question and the fact that I have had no part in constructing the HHS component of the President's Budget, I will look forward to addressing the matter with you upon release of the budget.

The MMA established a "stabilization fund" to attract and retain regional PPO plans in Medicare. However, the rules for plans to access these funds - an estimated $12 billion available beginning in 2007 – are not straight-forward, and as a consequence, plans tell me that they aren't counting on drawing down any funds from this pool. In addition, local managed care plans are concerned that the pool creates an unlevel playing field to their disadvantage. Given the budget deficit, Congress should revisit the stabilization fund and, I believe, consider eliminating it. Would you support this policy in light of the deficit?

Answer:

It was Congress' intent that the regular payments authorized by the MMA will create a variety of options for beneficiaries. In order to maximize plan participation, the statute also gives the Secretary of Health and Human Services several tools to attract and retain regional Preferred Provider

Organization (PPO) plans. One of these tools is the creation of the Stabilization Fund. I believe that we should ensure that the statutory intent of creating a range of beneficiary options is fulfilled and look forward to working towards this end.

HEALTH CARE QUALITY AND INFORMATION TECHNOLOGY:

Outgoing HHS Secretary Tommy Thompson and CMS Administrator Mark McClellan have spoken frequently of the need to move forward with policies that foster quality improvements in health care. McClellan has suggested that paying providers based on quality, so-called "pay-for-performance," is one way to foster quality care. What role do you think pay-for-performance should play in the Medicare and Medicaid programs? Will you commit to providing technical assistance in the development of pay-for-performance legislation?

Answer:

Encouraging improved health care quality is a top priority of mine and of the President's. The Administration has promoted accountability for quality, creating incentives to collect data from Medicare providers on quality measures. I am intrigued by the possibility of approaches to link Medicare reimbursement to provider performance. While I certainly am not versed in the variety of ways that pay-for-performance could be incorporated into the Medicare and Medicaid payment systems, I am excited to be involved in conversations regarding the issue. If I were to be confirmed, I would expect the Department would continue to pursue this issue and I would want us to work with the provider and beneficiary communities and the Congress in doing so. As Secretary, I would look forward to working closely with the Congress on this critical issue and would be happy to provide any technical assistance I could to aid in the development of pay-for-performance legislation.

Last year, I introduced the "Medicare Quality Improvement Act" (S. 2562), which would begin tying Medicare payments to performance on quality indicators, starting with Medicare Advantage and the End Stage Renal Disease program payments. The legislation echoed MedPAC's recommendations on pay-for-performance and called for a roadmap for tying payment to performance across all of Medicare. What is the Administration's position on my bill? Can I count on you to work with Chairman Grassley and me during the next year to provide technical assistance in developing pay-for-performance legislation?

Answer:

I understand that the Administration has not taken an official position on the "Medicare Quality Improvement Act" and I am not prepared to endorse any particular solution today. However, improving the quality of health care is a top priority for this Administration and I intend to promote policies that will continue this effort.

As I mentioned earlier, I am intrigued by the possibility of linking reimbursement to provider performance across the Medicare program. If I were to be confirmed, I would expect the Department would continue to pursue this issue and I would want us to work with the provider and beneficiary communities and the Congress in doing so. As Secretary, I would look forward to working closely with you and Chairman Grassley on this critical issue and would be happy to

provide any technical assistance I could to aid in the development of pay-for-performance legislation.

As Governor of Utah, you established a web portal for citizens to access social services and the Utah Health Information Network, both of which are examples of innovation and thoughtfulness. As you look at these issues at the federal level, how do you think that the federal government can best encourage the adoption and use of health information technology? What do you think the federal government's role should be in this process? And what do you think is the most essential first step?

Answer:

I believe that the federal government can play a critical role in encouraging and facilitating the adoption and use of health information technology, and I am keenly interested in this issue. I am proud of the advances that we were able to accomplish in Utah through our health and social services web portal. And I am very confident that the use of health information technology nationally can and will move our health care industry forward, simultaneously improving efficiency and productivity and reducing overall health care costs. As you know, the Department is now collecting and reviewing public comments on many questions related to how a nation-wide interoperable health information technology infrastructure could be established to ensure low-cost, secure data movement. These responses will inform our policy decisions in the near term. The Department is also evaluating the possible financial and non-financial incentives and disincentives, both public and private, which slow the adoption of electronic health records. I look forward to the opportunities that lie ahead in the area of health information technology, and will work closely with you in that process.

We have heard from health care providers that current Stark regulations present a barrier to the adoption of health information technology by limiting the ability of a hospital, for example, to assist physicians with the acquisition and use of new hardware and software. Dr. McClellan and others have suggested that revisions to the Stark law may be necessary to allow hospitals to assist physicians in the acquisition of technology for e-prescribing. Can you be more specific about what changes the Administration plans to make to the Stark laws to address current barriers to the adoption of health information technology? When can we expect these proposed changes?

Answer:

As you know, the Medicare Modernization Act mandates the creation of a new Stark exception for that would allow hospitals, physician group practices, PDP sponsors, and MA organizations to provide to physicians hardware, software and other services "necessary and used solely to transmit e-prescribing information". I understand that CMS is currently preparing a notice of proposed rulemaking on this new Stark exception.

I am not prepared today to discuss potential changes to the Stark law. Nonetheless, I believe that the federal government can play a critical role in encouraging and facilitating the adoption and use of health information technology. And I am very confident that the use of health information

technology nationally can move our health care industry forward, in terms of quality as well as efficiency and productivity. I look forward to the opportunities that lie ahead in the area of health information technology, and will work closely with you in that process

Hospitals operating in rural and underserved areas are least likely to be able to find the capital necessary to invest in health information technology. In fact, some Montana hospitals tell me that it cost them almost as much to report the hospital quality indicators to CMS as they would lose in the market basket update under the MMA if they did *not* provide these data. What is your view on the best way to provide assistance to spur adoption of information technology for these facilities?

Answer:

As you are well aware, rural and underserved areas across the country experience a unique set of challenges, especially in the area of health care. Unfortunately, these areas have the most difficult time recruiting and retaining health professionals to fulfill the health care needs of their communities. They are also less likely to have adopted health information technologies in their hospitals and may have limited resources for investing in these new technologies. As you know, the Health IT Strategic Framework identified some potential mechanisms to help support, or remove barriers to, the adoption of health IT, and encouraged further thought be given to these issues. As we consider ways to encourage the adoption and use of health information technology nationally, it is critical that we take into account the unique conditions in rural and underserved areas; and I look forward to working with you in this area.

Experts on health information technology have proposed establishing a revolving loan fund to help health care providers confront the financial barriers to implementing health information technology. Revolving loan funds in the area of environmental policy, such as the Drinking Water State Revolving Loan Fund, the Clean Water State Revolving Loan Fund, and the Brownfield Initiative, demonstrate that this model can be successful. How do you think we can use a revolving loan fund model to meet the President's goal of providing nationwide access to electronic medical records within the next decade?

Answer:

A revolving loan fund is one of a number of possible strategies that have been proposed for reducing financial obstacles to health information technology implementation. I look forward to working with Congress to evaluate the various potential strategies that have been identified and to fulfilling the President's vision for health IT.

There are a number of activities currently under way that will move us toward nationwide adoption of health information technology, including the work of the Commission on Systemic Interoperability and the Certification Commission for Health Information Technology. What is the timeline for generating reports and implementing the conclusions and recommendations of these groups? Will the Administration commit to holding true to these deadlines? What resources will be required to implement the recommendations of these groups, and when do you expect this implementation stage to take place?

Answer:

The Commission on Systemic Interoperability held its first meeting earlier this month. The Certification Commission for Health Information Technology, a private sector, voluntary coalition, has already met several times. Both Commissions represent unique and valued perspectives on possible ways to move the health care industry and the nation forward in the adoption and use of health information technology. As you know, the MMA directed that the Commission on Systemic Interoperability make its report by October 31, 2005. I look forward to the completion of their work and to reviewing their report.

Over the past year, the Departments of HHS, Veterans Affairs, and Defense, acting through the Consolidated Health Informatics initiative, have jointly adopted nearly two dozen standards relating to the transmission of health data. The joint adoption of these standards is a major step forward, provided that the agencies can follow through and drive the use of these standards by vendors. Can you please explain what steps HHS would take under your leadership to ensure the rapid incorporation of the adopted standards?

Answer:

As you know, HHS has made great strides towards encouraging and facilitating the adoption of health information technology through the Consolidated Health Informatics (CHI) initiative, which garnered consensus for standards across 20 health domains. CHI supports the adoption of standards in both the public and private sectors. The focus on HIT standards will be continued and expanded by the use of these standards(and additional standards as they are defined) in agency contracts and agreements and by working to assist in the implementation of these standards. HHS will also continue to encourage voluntary private sector implementation of CHI standards and collaboration to develop interoperability standards. Through these means, and other synergistic efforts, HHS will continue to aggressively make voluntary standards an integral part of health information technology today in both the private and public sectors.

UNINSURED

Countless polls – national polls, statewide polls, voter polls, a recent poll of health care opinion leaders – all find that providing health coverage to the uninsured is, or should be, a priority. Of course, there is less agreement on how best to expand coverage or how to pay for any new coverage. Since 2000, President Bush has proposed refundable tax credits for low-income individuals and families. Yet, the Administration has not actively pushed Congress to act on the uninsured. Moreover, the Administration's proposal has not generated bipartisan interest or support. How can we move forward and find common ground on ways to cover the uninsured?

Answer:

I would argue that the Administration has worked successfully with Congress to implement certain key components of the President's plan to reduce the number of uninsured. For example, with the

help of this Committee, the Medicare bill created Health Savings Accounts, which provide a new, more affordable option for millions of working Americans. That said, there are a number of equally important outstanding initiatives that I look forward to revisiting with you.

Back in November, White House officials talked about eliminating the exclusion of employer-provided health benefits from workers' taxable income in the context of tax reform. Since that time, however, I have not seen anything further regarding this proposal. Is this a policy direction that the Administration continues to support? Has the Administration conducted any analyses to show what impact this policy would have on the rate of health coverage in the U.S.?

Answer:

While HHS will continue to play a key role in meeting the President's goal to reduce the number of uninsured and expand access to health coverage, the specific concept you reference is actually within the jurisdiction of the Department of the Treasury.

Implementation of the TAA health care tax credit has raised some concerns, in my view. Enrollment has been extremely low, although it is increasing – but according to the Government Accountability Office, only 13,200 individuals were enrolled last July, out of an estimated 230,000 who were potentially eligible. Premiums were high; some enrollees were quoted rates more than 500 percent of the standard rate. And finally, administrative costs are extremely high – representing almost one-third of total program costs. Given this experience, what lessons do you think the TAA tax credit holds for the administration's tax credit proposal?

Answer:

Again, while HHS will continue to play a key role in meeting the President's goal to reduce the number of uninsured and expand access to health coverage, the TAA tax credit initiative is administered be the Department of the Treasury. I look forward to working with you and Secretary Snowe on a comprehensive approach to reducing the number of uninsured Americans.

INDIAN HEALTH

Congress has tried to reauthorize the Indian Health Care Improvement Act (IHCHIA) for three years, since an extension to the Act expired in 2001. At a hearing before the Senate Committee on Indian Affairs on July 21, 2004, outgoing HHS Secretary Tommy Thompson stated that he was committed to getting this bill passed. Unfortunately, the bill did not pass in the 108th Congress. American Indians and Alaska Natives are still waiting for reauthorization, and their vital health care programs have suffered as a result. What is your position on moving forward with reauthorization? What provisions in last year's legislation are most important to you, and what provisions represent areas of greatest concerns?

Answer:

Over the last 40 years, there have been significant health improvements among Indian people related to control of infectious diseases, expanded access to primary health care, and fundamental community infrastructure such as safe drinking water. Today, injuries, chronic diseases and behavioral related diseases such as alcoholism, substance abuse and mental health have emerged as leading challenges in Indian communities. HHS, working through the Indian Health Service, has a key role to play in working with American Indian and Alaska Native communities to improve health conditions through improved access to quality health care services, enhanced health care promotion and disease prevention, and focuses on new and emerging health issues facing these communities. The reauthorization of the Indian Health Care Improvement Act, which Congress was unfortunately unable to complete last year, could further support the efforts of HHS and IHS in these endeavors. As Secretary, I look forward to examining any reauthorization proposals and hope to work with Congress on these critical issues.

The ability of the Indian Health Service, Indian tribes, tribal and urban Indian organizations to access third party reimbursements, such as Medicare, Medicaid and SCHIP, is critically important to providing health care to Indians. What plans do you have to improve access to care for Native Americans through Medicare, Medicaid and SCHIP? What will the Department do to ensure that Indian tribes have input in proposals to change or revise Medicaid and other federal health programs?

Answer:

It is critically important to me that HHS work to maintain and improve access to care for all Americans, including Native Americans, and that Tribes' input is heard on issues affecting them. I will be reviewing Indian health efforts in the Department to see how well they are working and what improvements we can make.

The MMA specified that at least two drug discount cards must contract with pharmacies that serve Indian people. However, many Indians have encountered significant challenges in dealing with the drug discount card program, and take-up rates have been low as a consequence. I am concerned about whether Indian people will have adequate coverage and access to prescription drugs under the new Part D Medicare drug benefit, particularly since the proposed rule failed to include a requirement for prescription drug plans to contract with Indian Health Service or Tribal pharmacies. How will the Administration ensure that Indian people are able to participate in the Medicare prescription drug benefit and that the benefit and related consumer protections will meet the needs of this population?

Answer:

It is critical that American Indians and Alaska Natives be able to participate in the new Medicare prescription drug benefit. The NPRM for Part D indicated that two options to assure that Indian Medicare beneficiaries would be able to use the Part D benefit at the IHS, Tribal, and urban Indian organization (I/T/U) pharmacies many of them customarily use. I believe HHS should carefully

consider input on these questions, as well as experience with the Medicare approved drug discount cards so that we can increase the likelihood that the new Medicare prescription drug benefit will meet the needs of American Indian and Alaska Native Medicare beneficiaries.

For individuals who purchase medications from an IHS facility, the cost of those drugs cannot be used to fill the "donut hole" in the Part D benefit. Yet, CMS has proposed to allow certain charitable contributions to count toward filling the "donut hole." I am concerned that this will be a barrier to enrollment in the Medicare drug benefit for the Indian population. How do you propose to address this barrier?

Answer:

It is critical that American Indians and Alaska Natives be able to participate in the new Medicare prescription drug benefit, and we should work to address any potential barriers to awareness of or participation in the new benefits provided through the MMA. Nonetheless, I have not yet had the opportunity to review each of the issues relating to the implementation of the MMA, and I am not yet able to speak to each question in this area. I hope to work with CMS and the Tribes to ensure that the AI/AN population is able to fully make use of the opportunities provided in the MMA.

The Part D premium is also viewed as a serious barrier to enrollment in the Part D benefit for Indian populations. What is your position on the use of IHS-appropriated dollars to help pay the Part D premium?

Answer:

It is critical that American Indians and Alaska Natives be able to participate in the new Medicare prescription drug benefit, and we should work to address any potential barriers to awareness of or participation in the new benefits provided through the MMA. Nonetheless, I have not yet had the opportunity to review each of the issues relating to the implementation of the MMA, and I am not yet able to speak to each question in this area. I hope to work with CMS and the Tribes to ensure that the AI/AN population is able to fully make use of the opportunities provided in the MMA.

Indians rank at or near the bottom of nearly every health and social indicator when compared to the general population. Health studies indicate disproportionately higher mortality rates for alcoholism, tuberculosis, diabetes, accidental injuries, suicide, and homicide than other populations. In addition to these health disparities, native people suffer from high rates of unemployment and poverty, live in substandard housing, and receive an inadequate education. What is your plan to address and alleviate these disparities?

Answer:

Over the last 40 years, there have been significant health improvements among Indian people related to control of infectious diseases, expanded access to primary health care, and fundamental community infrastructure such as safe drinking water. Today, injuries, chronic diseases and behavioral related diseases such as alcoholism, substance abuse and mental health have emerged as leading challenges in Indian communities. One of the keys to addressing these problems is ensuring

access to health care. I look forward to working with Congress and the Indian Health Service, which plays a key role for the Department of Health and Human Services in providing access to care to American Indian and Alaska Native communities, to address these issues and reduce and eliminate health disparities. In doing so, it is critical that the IHS identify and collaborate with outside organizations with the capacity, capability, and interest to assist in addressing these diverse health problems. The IHS has developed partnerships and collaborations with other federal government agencies as well as academic, professional and other non-governmental partners. These partnerships cover a broad array of programs, including on health promotion and disease prevention.

Tribal sovereignty is an important issue for Native Americans, and it is also current Federal policy. Are you willing to support tribal sovereignty through Federal health programs?

Answer:

As you know, certain statutes provide for tribal self-governance, under which Tribes may operate certain Federal programs. The Tribal Self-Governance amendments of 2000 made permanent the ability of Tribes to operate their own health service programs through the Indian Health Service (IHS), and IHS program dollars are appropriated for this purpose. In addition to the IHS program, the Self-Governance Amendments of 2000 required the Department to conduct a study to determine the feasibility of a tribal self-governance demonstration project for appropriate programs, services, functions and activities. A report to Congress on this study was submitted by HHS to Congress on March 12, 2003. This report identified 11 HHS programs that might be included in a demonstration. I look forward to working with Congress on this issue in the future.

The health care facility on the Fort Peck reservation in Montana is in need of replacement, according to a resolution passed in November 2004 by the Fort Peck Tribal Executive Board. But the tribe has been told that Indian Health Service does not have funding available to help people at Fort Peck construct a facility sufficient to provide adequate, quality care to residents. In fact, the Fort Peck facility is not currently on any priority list for construction, apparently because there are so many facilities at even greater levels of disrepair. Will you commit to taking a closer look at the level of need in Fort Peck through an assessment of the Verne E. Gibbs ambulatory health care facility?

Answer:

Reducing health disparities is a key priority of the Department. The Indian Health Service, in consultation with Tribes, is revising its health care facilities construction priority system to better identify and prioritize health care facility needs. In the context of these ongoing consultation efforts, the Indian Health Service is committed to reviewing the level of need in Fort Peck for health care services and facilities as part of this revised priority system.

OTHER HEALTH-RELATED QUESTIONS

As Governor of Utah, you opposed legislation to create federal Association Health Plans that would be exempt from state regulation of health insurance. Do you still oppose this legislation?

Answer:

I understand the benefit of helping small businesses to provide affordable health insurance coverage for their workers by banding together to negotiate on behalf of their employees and their families. And I believe that we need to do everything we can to give America's working families greater access to affordable insurance. The Administration's proposal would increase the number of insured small firm employees and dependents and would produce savings for participating small businesses. One of the concerns about AHPs is that plans would choose to cover only the healthiest workers. However, there are ways to ensure that AHPs pool together a diverse range of health risks and to safeguard against destabilization of the private market. If AHPs are implemented, I am confident that the Department of Labor would effectively administer its certification and oversight responsibilities.

Last week it was reported that health spending in the U.S. increased by 7.7% in 2003, faster than the growth in the economy as a whole. Health spending now accounts for 15.3% of the nation's GDP. And while the rate of growth in prescription drug spending slowed relative to recent years, spending on drugs still increased by 11% in 2003. As Secretary of HHS, what steps do you intend to take to control high and rising health costs? Do you support efforts to study the clinical effectiveness and appropriateness of health services and treatments, and the health outcomes associated with such services and treatments?

Answer:

It is critical that we take strong and decisive steps to respond to the continuing increases in health care costs. The President has proposed a number of steps, including putting an end to the out-of-control medical litigation costs, harnessing the power of health information technology, taking steps to reduce medical errors, increasing the use and availability of generic drugs, and making prescription drugs available under Medicare, to make health care more affordable. I look forward to continuing these efforts and working to make health care more affordable and more accessible for all Americans. As part of these efforts, the Medicare Modernization Act included an authorization for research on the clinical effectiveness of health care services and treatments, and the recent Omnibus Appropriations bill included funding for these efforts. I intend to ensure that this work is implemented consistent with Congressional intent.

Last November, the Finance Committee held a hearing to explore the issues surrounding Merck's decision to withdraw its drug Vioxx from the market due to concerns about patient safety. During that hearing, we talked about proposals to establish a national registry of clinical trials to provide access to results of research on drugs for the benefit of researchers, health care providers, and the public. I would like to get your thoughts on this issue. What is your view on requiring clinical trials to be registered in a public database and public reporting of results?

Answer:

The collection and dissemination of information about clinical trials and their outcomes is an important consumer and health practitioner issue. Working together and in collaboration with our sister agencies in the DHHS, we implemented section 113 of the Federal Food and Drug Administration Modernization Act of 1997 (FDAMA) with the establishment of ClinicalTrials.gov in February 2000. Today, ClinicalTrials.gov contains information on more than 11,000 publicly and privately funded trials. Most of the trials are efficacy studies of treatments for serious or life-threatening diseases or conditions. In addition, for some of the completed studies in ClinicalTrials.gov, links are also provided to publications or abstracts describing the study's outcome.

Section 113 of FDAMA does not require that sponsors submit all clinical drug trial information to ClinicalTrials.gov. Congress originally authorized the registry to provide patients with information to expand their access to clinical trials. NIH also includes information not now required by section 113, sometimes including links to results, so long as doing so does not conflict with section 113's provision for sponsor consent. If Congress were to enact provisions requiring sponsors to submit a broader range of information to ClinicalTrials.gov, including results, it would expand the scope of the existing law. However, we recommend that an expansion should not be undertaken without a thorough analysis of all the options and their impact on public health, careful evaluation of any unintended effects, and consultation with stakeholders to ensure that only high quality and useful information is provided to the public.

Recent public attention to the increasing availability of clinical trial information has made pharmaceutical companies more aware of the responsibility to list clinical trials in ClinicalTrials.gov. Moreover, many companies that previously listed "pharmaceutical company" in the drug sponsor field are now identifying themselves by their company name. More changes are still needed. FDA wants to continue to work with industry and encourage them to put more data into the registry. FDA and NIH will continue to work with sponsors to put required information into the registry.

The Administration has actively supported the passage of comprehensive medical liability tort reform. The Congressional legislation supported by the Administration during the 108th Congress, H.R. 5 and S. 11, would have given medical product manufacturers, producers, and suppliers the same protections against liability as health care providers and plans. In addition, H.R. 5 and S. 11 would have created additional liability protections for punitive damages in cases involving FDA-approved products. In light of the recent events involving pain medications, such as the arthritis drugs Vioxx, Celebrex, and Bextra, does the Administration continue to support such broad-based liability protection for drug manufacturers? In my view, these protections could make it significantly more difficult for patients injured by unsafe medical products to receive fair compensation for their losses. How will you work with Congress in a bipartisan manner to address these concerns?

Answer:

Your question raises important points that should be discussed during the debate on this issue. The Administration issued a Statement of Administration Policy (SAP) in regards to medical liability tort reform which remains our official position on the issue.

Given the recent interest in drug safety, I am interested in the FDA's current work on Follow-On Biologics or Biogenerics. Is the FDA currently equipped to establish a pathway to approve Follow-On Biologics in a way that does not compromise patient safety?

Answer:

FDA is always concerned about patient safety. With regard to "follow-on" proteins, many scientific, legal, and policy questions need to be answered. Currently, FDA is conducting a public process to examine these issues. This process will ensure that FDA's approval authority is fully examined and that all interested parties have an opportunity to comment. When this process is complete, FDA intends to provide guidance to industry to clarify, consistent with our legal authority, the approval pathway and principles for review of such products, which will protect the public health.

TANF

Welfare reauthorization has been stalled in Congress for 3 years. We are currently operating the program under the 8th extension. There have been several bipartisan approaches to reauthorizing the welfare program. The Bush Administration has recommended strict and less flexible policies that have alienated many law-makers in Congress and on the state level. The emphasis on increasing work hours and participation rates without increasing childcare or other supports for families has created a roadblock. How do you intend to break this gridlock on welfare reauthorization?

Answer:

The President's plan to build upon the success of the 1996 welfare reforms was announced nearly three years ago after consultations with state and local partners. The goals of the plan were to help more welfare recipients achieve independence through work, promote strong families, empower States to seek new and imaginative solutions to help welfare recipients achieve independence, and show compassion to those in need. The strategy for achieving those goals was a key combination of maintaining successful policies, increasing state flexibility, and providing a renewed emphasis on work as the key to family self-sufficiency. The President's vision for welfare reform was adopted twice by the House of Representatives but, regrettably, has had a more difficult path in the Senate. It is my intention to continue the tremendous efforts of Secretary Thompson to work with you, Chairman Grassley and the other members of the committee so that a good bill can be brought to the Senate floor and approved with the broad support of the Senate.

Plainly and simply, President Bush's goal, Secretary Thompson's goal, my goal, is the same as that of every member of this committee: to treat those in need with compassion and respect and to help

those barely subsisting on welfare to achieve the dignity of work that leads to self-sufficiency. I hope and trust that the House and Senate will be able to pass welfare reauthorization this year, and I look forward to working with you to do so.

Utah was one of the States that responded to a 2002 NGA survey on the Administration's TANF reauthorization proposal. In its response to the survey, the Utah welfare administrator reported that the Administration's TANF proposal would force the state to abandon successful state strategies. More specifically, the Utah response stated:

> ***"Yes, a major redirection of resources and policy would occur [under the Bush Administration's proposal]. Utah would likely have to abandon the universal participation approach based on individualized employment planning. Employment counselors would become worksite developers and monitors instead of negotiating individualized employment plans tailored to meet the customer's needs to be employed."***
>
> ***"Resources would have to be diverted from current services such as pregnancy prevention, training programs, marriage initiatives, fatherhood programs, and other child well being initiatives in order to meet the cost of providing worksites to meet the work requirements".***

As a former Governor faced with the prospect of implementing the President's TANF proposal, will you consider any changes to this proposal before re-submitting it to Congress this year?

Answer:

Many states responded to the initial NGA survey prior to having details of the Administration's plan and prior to development of legislation in both the House and the Senate. In fact, the Administration's proposal incorporates a key element of Utah's TANF program: universal engagement. I believe that it is critically important that all clients have an individualized plan leading towards self-sufficiency. The Administration's plan also provides for increased State flexibility to count short-term training and treatment of conditions that are barriers to work, such as substance abuse and domestic violence. These activities are already included in Utah's welfare program, but the State currently receives no credit towards the federal participation rate requirements for these efforts.

Healthy marriage, responsible fatherhood and improved child well-being are key ingredients of the Administration's plan to strengthen welfare reform. While the bills considered in the last Congress differ in the details, they share with the Administration's plan the principles of emphasizing work, healthy marriage and state flexibility. I believe Utah is well-positioned to use this flexibility in order to achieve success in promoting self-sufficiency. I look forward to sharing my experience from Utah with our State partners and continuing to learn from their efforts.

State waivers and flexibility have helped many States create programs that cater to the specific needs of low-income families in their communities. Such waivers and flexibility helped

establish Utah's well-regarded welfare program in your time as governor. How will you address the issue of state flexibility in TANF?

Answer:

TANF continues to be one of the best examples of the power of state innovation and flexibility. The policies included in the Personal Responsibility and Work Opportunity Reconciliation Act embodied many of the reforms that began as state experiments through waivers of federal requirements under the old Aid to Families with Dependent Children (AFDC) program. In creating the Temporary Assistance for Needy Families (TANF) program, Congress acknowledged the immense capacity of states and localities to design and conduct effective social programs, and incorporated the lessons learned from AFDC waivers into the TANF program.

The Administration's welfare reauthorization plan gives states increased flexibility to count certain activities as meeting the work requirement for limited periods of time. States could receive credit for families engaged in short term substance abuse treatment, rehabilitation and work-related training designed to maximize self-sufficiency through work. The proposal also would allow States to spend TANF funds carried over from previous years on any benefit, service or other allowable TANF activity. This change, which would greatly increase State flexibility, is based on the recognition that cash benefits represent only one part of the services funded by TANF. I believe this increased flexibility is consistent with the lessons we learned from state waivers.

Given Utah's experience with promoting marriage, how do you plan to address issues surrounding family strengthening while keeping issues of safety and privacy in mind?

Answer:

A growing body of research has highlighted the benefits for children of growing up in married-parent families. The differences in well-being between married-parent families and other families persist even after controlling for other family characteristics such as race and education that might affect child outcomes. This includes both short-term benefits, and benefits that last into adulthood.

For example, children who grow up in married-parent families are far less likely to be poor, have better educational attainment, are less likely to have health problems and psychological disorders, are less likely to have committed crimes, and are less likely to give birth as a teen than children who grow up single-parent families. Several studies also find that as adults, children who grew up in married-parent families are more likely to go to college and attain better labor market outcomes.

This gives us a strong interest in promoting healthy marriages. And all of our family strengthening and marriage activities must be strictly voluntary and include safeguards to screen for domestic violence. The intent of our current and planned efforts is to make services available (and known) to couples and individuals who might benefit from them and who are interested in them. It is not intended that anyone be coerced into marriage or healthy marriage services.

Safety is of the utmost concern. These kinds of programs are intended to help people form healthy and respectful relationships and marriages that should reduce the risk of abuse and violence.

Domestic abuse and violence is an extremely serious problem that is far too frequent in marriages and non-marriage relationships. Healthy marriage programs do not push people into marriages, but help them understand how healthy relationships and marriages work and help them assess their own relationships realistically. About 15% of couples who participate in pre-marital education training decide not to get married – because they come to learn they are either not ready for marriage or some aspect of their relationship is fundamentally flawed, including violence, making marriage a poor choice. Unhealthy, abusive and sometimes violent relationships form and can get worse in part because of a lack of understanding by partners about how they should act and what they should expect from each other. Healthy marriage skills-building can help, and I will insist that states involve local domestic violence experts in the development of the service plans they propose for funding.

What are your plans for supporting Tribes to establish welfare programs?

Answer:

The Administration's welfare proposal would continue to allow American Indian Tribes and Alaska Native organizations to elect to operate their own tribal TANF programs to serve eligible Tribal Families. As of Fiscal Year 2002 year's end, 36 Tribal TANF plans were approved to operate on behalf of 175 Tribes and Alaska Native villages. HHS has worked closely with tribes developing tribal TANF plans to negotiate appropriate targets for work participation and to improve the data on which the allocation of Tribal TANF funds are based.

I expect to continue the Intradepartmental Council for Native American Affairs in 2002, which was reconstituted by Secretary Thompson in 2002. The Council membership includes the heads of each HHS Division and serves as the Secretary's principal advisory body on tribal policy matters. The Intradepartmental Council on Native American Affairs develops recommendations for solutions to improve American Indian, Alaska Native, and Native American (AI/AN/NA) policies and programs, provide recommendations on how HHS should be organized to administer services to the AI/AN/NA population, and ensures that the HHS policy on tribal consultation is implemented by all HHS divisions and offices.

ACF Administrator Wade Horn has continually cited falling caseloads as a reason States no longer need child care funding or inflation increases. As a former Governor, however, you know – and GAO has confirmed – that States have simply shifted away from cash benefits in order to provide child care and other work supports for low-income families. Do you agree with Dr. Horn that state success in moving people from cash to non-cash services should result in reductions in federal funding?

Answer:

Welfare reform has been a resounding success, not only because of caseload decreases, but also because of increases in employment. Over a quarter of welfare recipients were working in fiscal year 2002, compared to 11 percent in fiscal year 1996, and less than 7 percent in fiscal year 1992. In addition, welfare caseloads are at their lowest levels in over 30 years. As of March 2004, fewer than

two million families and 4.8 million individuals were receiving assistance through the TANF program, down 55 percent and 61 percent, respectively, since the enactment of TANF.
Despite the dramatic caseload declines, the Administration's welfare reauthorization proposal would maintain the current level of funding. Full funding will allow states to continue their recent investments in welfare-to-work programs and post-employment supports – such as transportation, child care, and training – that enable families to retain employment, enhance skills, and move up the career ladder. In addition, the welfare reauthorization proposal would give states the ability to use unobligated TANF funds carried over from previous years on services.
We all agree that child care and support services are essential for families to achieve self-sufficiency through work. The Administration's welfare reauthorization proposal maintains funding dedicated to child care at its historically high levels. Moreover, as caseloads have declined, states have increasingly used TANF funds for child care, either by transferring funds to the child care block grant or through direct payments out of the TANF block grant. States would continue to have that flexibility.

Many of the welfare recipients who moved from welfare to work in the 1990s lost their jobs in the 2001 recession, although the cash assistance rolls continued to decline. The Administration for Children and Families insists that these people must be getting unemployment benefits, but fewer than 7 percent of poor children lived in families that received unemployment compensation in 2003. In fact, GAO has told us that it's highly unlikely that people who earn less than $8.50 an hour (and studies show nearly all welfare leavers are in that category) qualify for unemployment. What do you think is happening to those families? Do you believe we have an obligation to help them?

Answer:

Former welfare recipients who transition from welfare to work have greater access to unemployment benefits now than was true for welfare recipients in the 1980s, or even during the mid-1990s, the time of the GAO study. Studies of women leaving welfare for work in the late 1990s through 2001 have found that 50 to 70 percent of these women have sufficient earnings to qualify for unemployment benefits if they experience a job loss a year after exit. While some of these women may be are subsequently disqualified for non-monetary grounds or may not apply for benefits, access of former welfare recipients to unemployment benefits has improved substantially over the past decade. This is also supported by data from the Current Population Survey, which shows a significant increase in receipt of unemployment benefits among single mothers between 2000 and 2003.

This recent increase in use of unemployment benefits is likely due to the dramatic increase in employment among single mothers since enactment of welfare reform in 1996. As noted in a report issued by the Urban Institute last week, the proportion of single mothers holding jobs was 70 percent in June 2003 -- which was below the peak of nearly 75 percent in late 2000, but still much higher than the 64 percent in August 1996. As data becomes available for 2004, we can expect further improvement as the economy continues to grow. Over 2.0 million jobs were added to the U.S. economy between January 2004 and December 2004, with an average monthly increase of about 173,000 new jobs.

Leavitt Confirmation
Baucus Questions for the Record

I hope we all can agree that work is a better prospect for ensuring economic well-being than remaining on welfare. Work must remain the focus of our welfare policy, regardless of the economic conditions.

At the same time, we know there are some families who face significant challenges in finding and maintaining work. Congress recognized this in providing for a state option, under TANF, for exempting up to 20 percent of the TANF caseload from termination from time limits due to hardship. This option, as well as the ability to use state-only Maintenance of Effort (MOE) funds, gives states great flexibility in responding to economic circumstances.

In several reports, GAO has recommended that HHS do more to provide guidance and technical assistance to states to improve their child welfare programs. For example, while states have made progress in implementing information systems to administer and track child welfare programs and outcomes, better data are needed to improve oversight. What steps will HHS take to work with states to move ahead in this area?

Answer:

In recent years HHS has placed a great deal of emphasis on improving its oversight of state child welfare programs, and has initiated a process by which states are held accountable for real outcomes for children. These Child and Family Services Reviews (CFSRs) are designed to help States improve child welfare services and the outcomes for families and children who receive services by identifying strengths and needs within State programs, as well as areas where technical assistance can lead to program improvements. The reviews emphasize accountability and are conducted in collaboration between State and Federal governments.

Improved data on children who are the subjects of child maltreatment reports or in foster care have been a necessary condition for the Department's emphasis on outcomes. The data included in the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) are considerably more reliable and robust than they have ever been, and are becoming more so with every passing year. And each year as well, more State Automated Child Welfare Information Systems are becoming operational, providing not only improved federal data, but also allowing states to use information more effectively to manage their service systems on a daily basis. In addition, data are just becoming available from the National Study of Child and Adolescent Well Being, (NSCAW), which was authorized with TANF in 1996. This will be the first national study that examines child and family well-being outcomes in detail and seeks to relate those outcomes to their experience with the child welfare system and to family characteristics, community environment, and other factors.

The 1996 welfare reform legislation created a $16 billion block grant to provide funds to states to operate their welfare programs. With the flexibility provided states, they can keep some federal funds in reserve to meet future program needs. Yet, GAO found that HHS does not have enough information to understand the extent to which states' "reserves" are actually available to meet future needs, because of the way states report the data. Can you talk about the role HHS will play in ensuring it has the right information for oversight and to provide policymakers key information?

Answer:

There is general agreement on the need for better reporting on the TANF block grant "reserves" that are available to meet future program needs. While current law allows States to carry over funds from year-to-year, there is no clear way for States to indicate that the carried-over funds are purposely set aside as a "reserve" against difficult economic times, rather than simply unspent. The Administration's proposal would allow States to designate some or all of their carried-over funds as "Rainy Day Funds" and clarify that such funds would be treated as obligated for reporting purposes. This proposal received widespread support, and was included in the bill passed by the House last session, as well the bill reported by this Committee.

The Administration's proposal and last session's legislation also would revise current restrictions which limit the use of carried over funds only to expenditures on "assistance." States would be allowed to spend such funds on any service or benefit that achieves a TANF purpose, not just cash benefits.

Finally, the Administration's plan supports better reporting on expenditures of TANF block grant funds. With the dramatic drop in cash assistance caseloads, less than half of all funds are spent on services and supports other than cash benefits. Thus it is time to improve annual reports on all TANF and Maintenance of Effort (MOE) programs to collect some basic information (e.g., number of beneficiaries and amount of expenditures) that is not otherwise available on non-cash assistance programs. While improved data reporting has to be designed carefully, and in consultation with states in order to avoid undue burden, it is in everyone's best interest – including that of the States—to have reports that enable HHS to better inform Congress about how the TANF block grant funds are being spent.

GAO has recommended that HHS do more to collect the data it needs from states and localities to improve several programs, including Head Start and Child Support Enforcement. What steps will HHS take work with its partners to ensure it has the data it needs while minimizing the reporting burden on those receiving funds?

Answer:

Yes, better data collection is needed to improve program performance. We agree that this is extremely important and we will work closely with states and localities toward this goal. The Child Support Enforcement program will also be greatly improved by passage of the Child Support provisions proposed by the Administration, many of which were included in the TANF Reauthorization bill reported by this Committee. These proposals will improve rigorous enforcement of child support obligations while targeting additional child support collections to the families with the greatest need. Altogether, when passed, these proposals will increase child support collections to families by $3 billion over five years, at a federal cost of $105 million. The proposals are significant piece of TANF reauthorization, and on their own do much to improve the Child Support Enforcement program, particularly for the most vulnerable families. I look forward to working with Committee members in this important legislation.

January 14, 2005–DATA AND INFORMATION REQUESTED BY SENATOR BAUCUS:

B1. Detailed accounting of the $1 billion provided in federal funding by the MMA for HHS to implement the drug benefit and reforms. How did HHS use this money?

Response:

CMS has a very robust plan to spend the $1 billion MMA implementation appropriation. Our prime directive in allocating these funds is to ensure that the new benefits and programs that the MMA made available for our beneficiaries are implemented on time and efficiently.

These are a few of our major priorities:

- Enhancing Beneficiary and Provider Outreach - $436 million, 44 Percent. The only way that the MMA will be successful is if we are successful in educating our beneficiaries, providers and other partners about how the MMA will impact them.

  Our investments in this area include: enhancing the functionality and availability of 1-800-MEDICARE, creating new functionality for our web sites, expanding our capacity - through local partnerships - to interact on a 1:1 basis with our beneficiaries and creating an information sharing network to ensure that employers, providers and plans understand the implications of the MMA.

- Staffing CMS to Meet the Mandates of MMA - $44 million, or only 4.4 percent. CMS' current human capital investments are correct for the pre-MMA world. However, MMA drives us to a new way of doing business and we want a workforce that has the skills and knowledge to interact effectively in this new environment, be responsive to beneficiary needs, and provide leadership for all of our providers and partners.

  We believe that up to 500 (on a base of 4,580) new FTE will be needed who: have experience with our new business partners, are versed in cutting edge outreach and education methods, have superior analytic skills for fraud detection and are on the cutting edge of the latest information technology.

- Using Private Sector Technology and Expertise to Drive Efficient Implementation - $276 million, 28 percent. We are making prudent investments in an information technology framework that will allow CMS to carryout its current obligations as well as implement MMA's reforms.

  Our information technology strategy: relies on investing in provide internet-based technologies to provide and process information, leverages existing technology to ensure that we are not duplicating systems, seeks voluntary partnerships with

providers, plans and employers to decrease overall cost, and builds-in security and confidentially.

- Combat Fraud - $25 million, 2.5 percent. The Departments Office of Inspector General has been provided funding for this oversight role.

B2. "New" IGT rules that are being applied to States.

Response:

The focus on funding arrangements is one of compliance and enforcement rather than policy change.

In short, funding for Medicaid is a shared responsibility between the federal government and the states. The federal match rate is calculated annually and published in the Federal Register. Under Title XIX, states may share their cost of the Medicaid program with units of local government. Intergovernmental Transfers (IGTs) that meet the conditions for protection under the Medicaid statute are recognized as permissible sources of State funding of Medicaid costs. The statutory provision governing IGTs is an exception to the very restrictive requirements governing provider-related donations. The IGT provision was meant to continue to allow units of local government, including government health care providers, to share in the cost of the State Medicaid program.

Section 1903(w)(6)(A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider.

Under the plain language of this statutory provision, only units of local or State government are eligible to make protected IGTs. This ability to make protected IGTs is not affected by whether the unit of government is also a health care provider.

As mentioned earlier, section 1903(w) of the Act generally contains limitations on the use of donations or taxes from health care providers; these limitations would not apply to a protected IGT under section 1903(w)(6)(A).

B3. Criteria for HHS redistribution of the $660 million in expiring FY 2002 SCHIP funds.

Response:

This information will be made public on Tuesday, January 18, 2005 prior to the confirmation hearings.

B4. Medicaid enrollment and spending. For FY 2003, please provide, *for each state*, the following:

a. Number of beneficiaries enrolled by eligibility category;

See Attachment A

b. Total federal Medicaid funds expended;

See Attachment B

c. Federal Medicaid funds expended for health care services;

See Attachment B

d. Federal Medicaid funds expended on DSH;

See Attachment B

e. Federal Medicaid funds expended on administration;

See Attachment B

f. Federal Medicaid funds expended under section 1915(c) HCBS waivers;

See Attachment C

g. Federal Medicaid funds expended in excess of UPL limits prescribed under the Administration's January 18, 2002 regulations;

Attached (Attachment D) is an estimate of the fiscal impact of the UPL transitional phase-out amounts as a result of Congressional action under BIPA to qualifying states and subsequent regulations. CMS previously provided estimates to the General Accountability Office (GAO) for reports on implementation of BIPA and subsequent regulations.

The Federal dollars affected by these questionable financing arrangements associated with UPL transition amounts is difficult to determine because for the most part, all of the transition funds were returned by providers to the State for other uses. Some States used these recycled Federal funds as the state share to draw down additional Federal funds for other Medicaid program costs, while other States used the recycled Federal dollars to satisfy non-Medicaid activities which would be inconsistent with the payment exclusion under 1903(i)(17).

The estimates provided in the attached chart, therefore, may not reflect the full fiscal impact of the recycling practices. They represent only the initial excess payments and

do not take into account additional federal funds drawn through the iterative recycling process employed by at least some of the states.

h. Federal Medicaid funds expended through IGT arrangements that CMS considers inappropriate (*see* Baucus July 8, 2004 letter to McClellan);

Since August 2003, CMS has been requesting information from States regarding detail on how States are financing their share of the Medicaid program costs under the Medicaid reimbursement SPA review process. CMS makes a determination of whether a financing arrangement changes the federal match rate based on a state's response to a series of questions. (See Attachment E). Attachment F contains a complete list of the SPAs submitted to and reviewed by CMS since August 2003 and their status. Based on these reviews, CMS has approved a majority of state plan amendments.

During the SPA review process, CMS has discovered that several States make claims for Federal matching funds associated with certain Medicaid payments, payments of which the health care providers are not ultimately allowed to retain. Instead, through the "guise" of the IGT process, State and/or local government requires the health care provider to forgo and/or return certain Medicaid payments to the State (on the same day in most instances), which effectively shifts the cost of the Medicaid program on the Federal partner.

The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (a payment for which Federal funding was made available based on the full payment), and the State and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or to help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the Federal government bears a greater level of Medicaid program costs, which is inconsistent with the Federal medical assistance percentages specified in the Medicaid statute.

Some States used these recycled Federal funds to draw down additional Federal funds for other Medicaid program costs, while other States used the recycled Federal dollars to satisfy non-Medicaid activities which is inconsistent with the payment exclusion under 1903(i)(17). CMS recognizes that payments to providers made under the Disproportionate Share Hospital (DSH) program are for broader uses to include uncompensated care as well as Medicaid shortfalls.

i. Amount of federal Medicaid funds expended on services that is attributable to waste, fraud, or abuse;

CMS does not have this data available and it is almost impossible to collect these numbers because of the variables involved. When GAO entertained collecting this data, they determined that it would require a separate audit, with very tight definitions

and parameters and it would take from 6 months to a year, and variables would still be an issue. The only solid, readily available numbers are the Federal grant expenditures for the Medicaid Fraud Control Units (MFCUs), their work being fairly narrow and well-defined. For FY 2003 - $119.3 million and cumulative from FY '78 - FY'03 - $1.5 billion.

However, we have been fairly proactive in our overall goal of ensuring the program integrity of the Medicaid program. Our strategy for a number of years has been two-fold: 1) to assist states in their front-line anti-fraud efforts; and, 2) to provide oversight to ensure that states have the necessary processes in place to do this effectively. Outlined below are some examples of this dual approach.

In the area of oversight, CMS funds and provides both technical assistance and oversight of states' Medicaid Management Information System (MMIS). A vital part of each state system is the Surveillance and Utilization Review Subsystem, which through edits and examination of aberrant patterns which contribute significantly in the identification of cases of suspected fraud. These cases are then referred to the MFCU's which, in FY 2003, recovered $268 million in court restitutions, fines;, civil settlements, etc. CMS funds each state's MMIS at a 90% start-up level and at 75% for ongoing operations. In FY 2003, CMS' share of the funding was over $1.5 billion. Additionally, from an oversight perspective, CMS instituted a multi-year program of state Medicaid Program Integrity reviews designed to assess state anti-fraud efforts. To date, 37 reviews have been conducted, with eight more schedule for this fiscal year. Finally, this past August, CMS issued a proposed regulation implementing the Improper Payments Act of 2002, requiring states to measure improper payments. In anticipation of this, CMS has been working with states over the past three years developing methodologies that will ultimately produce state-specific error rates and a national error rate.

In terms of assisting states in their anti-fraud efforts, we have taken a more data-oriented approach. Additionally, we realize that there is great benefit in more closely coordinating program integrity efforts between Medicare and Medicaid. We have initiated a number of joint Medicare-Medicaid projects over the past few years, but the most notable example is the Medicare-Medicaid Data Match Project (Medi-Medi). This first-of-its-kind project matches and analyzes paid claims data from both programs in order to detect patterns that would not be evident when viewing data from one program or the other in isolation. This project is currently ongoing in nine large states and funding levels from all sources (HCFAC, MIP and the FBI) since the inception of this project four years ago total a little over $25 million. We are also working on a joint project to create one, universal provider enrollment process for Medicare and Medicaid.

j. Enrollment in the drug discount card and participation in transitional assistance.

B5. Section 1115 waivers:

a. What States are currently in discussions with CMS about 1115 waivers?

CMS is currently in discussions with the following states forty-one (41) states and the District of Columbia: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

b. What factors do CMS officials use to evaluate 1115 waiver applications?

Section 1115 waiver projects are evaluated to ensure that the project is likely to assist in promoting the objectives of title XIX or title XXI. CMS encourages state innovation and flexibility in the design of a waiver project so that the project is tailored to the needs of each state's low-income populations. Taking into consideration the unique state environment, CMS considers many factors when evaluating 1115 waiver application, such as previously approved demonstrations; statutory provisions and regulations; and beneficiary access to care and quality assurance. Furthermore, section 1115 waiver projects must not cost the federal government more than the Medicaid program would have cost without the project. When a state submits a section 1115 waiver application, it must show that it has adhered to the requirements for public input that are described in the Federal Register, Vol. 59, No. 186 dated September 1994 and, if applicable to the waiver, consulted with Native American/Alaska Native Tribes.

c. What is the Administration's "bottom line" in approving waivers? For example, Florida has considered time-limits on Medicaid benefits. Is that something the administration would support, or even encourage?

Each state's waiver application is reviewed within the context of the specific needs of the population in the state by the Federal review team which consists of Federal partners from within the Department of Health and Human Services and the Office of Management and Budget.

Limiting the time that certain beneficiaries can receive Medicaid is already incorporated into Medicaid law and is not new. Transitional Medicaid Assistance (TMA) is a mandatory Medicaid eligibility group authorized under section 1925. TMA for families who lose section 1931 eligibility due to income may receive up to 12 months of coverage. (If section 1931 were to sunset, the time limit will be four (4) months under 1902 (e)(1).) TMA for families who lose section 1931 eligibility due to child support payments may be eligible for 4 calendar months. Furthermore, States have routinely in their 1115 waivers that provide only family planning benefits restricted eligibility for a limited duration. If a state wanted to extend eligibility for a

1931 group, it certainly would receive serious consideration. We have not adopted a specific policy on time limits for expansion populations.

While Florida at one time was considering whether it would pursue time limits, we do not believe that the State is considering such now.

d. Federal Medicaid funds expended under section 1115 demonstration waivers?

See Attachment G

B6 Dual eligibles:

a. What percent of Medicaid costs are associated with dual eligibles?

Response:

Forty-five percent (See Attachment H)

b. Baseline projections for the next 5 and 10 years about how much of Medicaid costs will results from paying for benefits not covered by Medicare and its cost sharing for low-income seniors?

Response:

This information is not available, since we do not project Medicaid expenditures for the dual eligible population at the present time.

c. What fraction of Medicare cost growth is accounted for by the costs of dual eligibles?

Response:

This information is not available; the Medicare budget projections do not break out duals eligibles.

d. What is the projected growth rate for prescription drug spending in Medicaid over the next 5 and 10 years, including clawback payments?

Response:

Since the request does not specify the basis--total computable or federal share, gross or net of rebates, we've shown them all. (See Attachment I)

Attachment A

2002 MEDICAID ENROLLMENT BY BASIS OF ELIGIBILITY AND STATE

		BASIS OF ELIGIBILITY								
STATE	TOTAL ELG.	AGED	BLIND/DISABLED	CHILDREN	ADULTS	CHILDREN UNEMPL. PARENT	UNEMPL. ADULT	FOSTER CARE CHILD.	UNKNOWN	BCCA WOMEN
AK	121,400	6,569	12,271	73,283	25,520	679	1,082	1,938	-	58
AL	845,125	98,709	191,405	411,324	137,462	-	-	6,224	1	-
AR	608,017	50,510	108,792	304,343	138,151	-	1	6,206	14	-
AZ	1,053,602	43,667	109,978	505,858	386,179	-	-	7,920	-	-
CA	9,336,447	664,023	989,758	3,462,819	4,058,935	-	-	157,995	-	2,917
CO	438,670	47,555	66,257	219,718	87,722	-	-	17,297	97	24
CT	487,989	61,797	60,596	251,147	100,075	4,282	2,629	7,372	-	91
DC	204,591	13,747	43,794	88,534	51,827	-	-	6,689	-	-
DE	147,197	10,769	17,642	64,174	52,705	-	-	1,876	-	31
FL	2,691,502	255,655	522,310	1,267,968	478,467	63,658	60,075	43,369	-	-
GA	1,459,631	108,680	232,728	844,963	252,563	-	-	19,550	-	1,147
HI	195,684	17,396	23,627	86,034	62,685	-	-	5,942	-	-
IA	358,708	41,577	60,717	171,192	65,707	4,343	4,858	10,314	-	-
ID	196,406	12,968	26,651	124,773	29,809	-	-	2,205	-	-
IL	2,076,146	279,046	300,341	1,015,780	395,716	288	224	84,506	-	245
IN	881,942	78,441	116,543	521,163	152,889	-	-	12,730	-	176
KS	305,110	30,702	52,879	161,499	47,647	-	-	12,383	-	-
KY	769,826	72,121	207,955	370,090	110,257	-	-	9,403	-	-
LA	990,286	105,311	177,258	586,400	107,771	1,677	2,399	9,470	-	-
MA	1,204,312	116,164	243,326	482,300	361,857	-	-	665	-	-
MD	752,065	55,354	121,570	415,260	142,405	-	-	17,373	103	-
ME	346,449	71,964	119,321	95,608	54,147	1,548	954	2,907	-	-
MI	1,527,627	99,714	297,112	804,779	285,805	-	-	40,006	211	-
MN	680,627	69,759	93,872	333,759	174,200	-	-	8,983	-	54
MO	1,098,525	98,744	150,368	566,155	258,115	-	-	25,143	-	-
MS	707,986	74,033	161,410	384,360	84,985	-	-	3,159	39	-
MT	106,229	10,102	17,688	52,662	21,852	-	-	3,829	9	87
NC	1,389,455	178,258	236,259	699,139	259,289	-	-	16,510	-	-
ND	71,619	10,032	9,841	27,589	14,263	4,270	3,834	1,790	-	-
NE	266,245	23,526	29,885	150,254	51,583	-	1	10,267	661	68
NH	115,517	12,654	14,611	68,564	16,219	347	413	2,709	-	-
NJ	982,676	111,710	178,819	462,890	207,270	-	-	21,926	-	61
NV	203,251	19,562	33,202	92,475	43,718	3,255	2,920	8,119	-	-
NY	4,139,898	398,070	688,012	1,737,279	1,241,408	-	-	75,129	-	-
OH	1,754,379	144,622	279,463	916,303	364,459	8,184	7,017	33,937	394	-
OK	677,788	63,837	81,293	432,322	93,949	-	-	6,387	-	-
OR	637,140	44,325	68,379	241,461	256,666	6,302	4,845	14,987	175	-
PA	1,710,999	212,480	386,422	776,892	280,549	2,988	2,708	48,635	-	325
RI	204,789	19,667	38,418	88,794	52,218	-	-	5,522	-	170
SC	895,863	78,066	122,846	463,859	222,576	-	-	8,423	16	77
SD	113,925	10,139	16,420	67,273	18,157	-	-	1,922	-	14
TN	1,700,384	90,398	340,155	723,890	531,554	-	-	14,368	19	-
TX	3,202,171	383,307	379,541	1,852,717	512,724	17,424	21,914	34,544	-	-
UT	233,156	12,102	28,075	130,577	55,627	-	-	6,676	-	99
VA	727,784	98,274	139,382	378,017	96,980	18	20	14,946	1	146
VT	156,958	19,661	19,109	66,331	49,235	-	-	2,610	12	-
WA	1,104,813	79,445	145,928	579,553	283,130	54	183	16,520	-	-
WI	776,638	95,507	139,297	323,795	177,709	11,548	10,770	17,910	8	94
WV	362,264	29,678	89,755	176,271	54,070	6	5,808	6,676	-	-
WY	69,802	5,297	8,796	39,397	14,099	-	-	2,213	-	-
TOTAL	51,089,613	4,735,594	8,000,077	24,161,587	13,022,905	130,871	132,655	898,180	1,760	5,884

DATA SOURCE: MEDICAID STATISTICAL INFORMATION SYSTEM
NOTE: NEW MEXICO IS MISSING

Attachment B

Net Reported Medicaid Expenditures - Form CMS-64 - Federal Share
FY 2003

State	Medical Assistance Payments			ADM	MAP + ADM
	Health Care Services	DSH	Total MAP		
Alabama	$2,258,545,561	$249,689,858	$2,508,235,419	$78,210,631	$2,586,446,050
Alaska	546,694,848	9,135,000	546,694,848	37,880,516	584,575,364
Amer. Samoa	6,171,100	0	6,171,100	0	6,171,100
Arizona	2,999,892,209	116,295,225	2,999,892,209	109,798,070	3,109,690,279
Arkansas	1,769,349,220	23,235,541	1,769,349,220	73,460,178	1,842,809,398
California	15,768,565,921	927,364,158	15,768,565,921	1,133,119,190	16,901,685,111
Colorado	1,317,486,269	80,425,476	1,317,486,269	63,383,738	1,380,870,007
Connecticut	1,826,504,040	114,110,863	1,826,504,040	64,593,605	1,891,097,645
Delaware	372,510,520	1,339,800	372,510,520	26,956,669	399,467,189
Dist. Of Col.	769,212,310	26,838,399	769,212,310	42,381,638	811,593,948
Florida	6,603,449,252	159,296,986	6,603,449,252	304,067,260	6,907,516,512
Georgia	3,864,544,309	218,317,491	3,864,544,309	205,358,125	4,069,902,434
Guam	5,976,000	0	5,976,000	345,847	6,321,847
Hawaii	462,740,573	0	462,740,573	42,768,716	505,509,289
Idaho	588,759,233	7,283,369	588,759,233	44,234,842	632,994,075
Illinois	4,812,360,246	158,568,202	4,812,360,246	373,976,318	5,186,336,564
Indiana	2,717,770,593	150,580,781	2,717,770,593	111,814,738	2,829,585,331
Iowa	1,393,363,615	16,601,050	1,393,363,615	48,353,519	1,441,717,134
Kansas	1,087,513,456	25,341,323	1,087,513,456	55,348,069	1,142,861,525
Kentucky	2,638,488,334	117,740,000	2,638,488,334	64,305,180	2,702,793,514
Louisiana	3,211,925,836	587,395,235	3,211,925,836	99,329,586	3,311,255,422
Maine	1,210,195,787	28,378,197	1,210,195,787	46,716,093	1,256,911,880
Maryland	2,250,617,580	29,487,473	2,250,617,580	155,606,047	2,406,223,627
Massachusetts	3,954,945,596	205,135,108	3,954,945,596	209,514,321	4,164,459,917
Michigan	4,563,526,130	240,541,999	4,563,526,130	273,908,579	4,837,434,709
Minnesota	2,505,819,460	29,137,610	2,505,819,460	149,629,972	2,655,449,432
Mississippi	2,227,250,556	125,393,926	2,227,250,556	65,530,176	2,292,780,732
Missouri	3,477,225,751	321,619,417	3,477,225,751	137,955,136	3,615,180,887
Montana	387,357,405	155,140	387,357,405	17,987,544	405,344,949
N. Mariana Islands	6,005,089	0	6,005,089	144,912	6,150,001
Nebraska	810,884,567	(226,657)	810,884,567	42,210,770	853,095,337
Nevada	548,798,253	37,555,001	548,798,253	42,775,633	591,573,886
New Hampshire	470,555,954	102,072,321	470,555,954	38,155,808	509,711,762
New Jersey	4,032,443,388	556,878,894	4,032,443,388	277,695,851	4,310,139,239
New Mexico	1,539,538,215	4,523,065	1,539,538,215	42,961,094	1,582,499,309
New York	20,543,337,976	1,201,032,659	20,543,337,976	650,486,652	21,193,824,628
North Carolina	4,520,695,624	230,057,911	4,520,695,624	171,895,548	4,692,591,172
North Dakota	334,117,482	989,362	334,117,482	12,006,205	346,123,687
Ohio	6,147,384,482	140,095,245	6,147,384,482	194,518,071	6,341,902,553
Oklahoma	1,681,223,561	16,240,000	1,681,223,561	101,860,914	1,783,084,475
Oregon	1,665,357,002	22,999,422	1,665,357,002	135,920,040	1,801,277,042
Pennsylvania	7,181,462,567	353,969,198	7,181,462,567	340,443,753	7,521,906,320
Puerto Rico	397,912,981	0	397,912,981	36,000,000	433,912,981
Rhode Island	816,205,476	52,680,937	816,205,476	47,092,279	863,297,755
South Carolina	2,526,270,590	241,701,311	2,526,270,590	79,946,155	2,606,216,745
South Dakota	376,307,571	701,933	376,307,571	10,836,831	387,144,402
Tennessee	4,211,212,123	0	4,211,212,123	272,102,238	4,483,314,361
Texas	9,490,054,841	791,785,561	9,490,054,841	441,560,500	9,931,615,341
Utah	796,806,768	8,797,889	796,806,768	46,456,666	843,263,434
Vermont	453,385,626	18,260,630	453,385,626	37,851,763	491,237,389
Virgin Islands	7,850,736	0	7,850,736	1,065,168	8,915,904
Virginia	1,855,782,421	78,470,827	1,855,782,421	126,857,855	1,982,640,276
Washington	2,641,403,102	139,280,845	2,641,403,102	242,759,564	2,884,162,666
West Virginia	1,424,820,633	58,218,603	1,424,820,633	54,801,069	1,479,621,702
Wisconsin	2,881,290,864	25,957,026	2,881,290,864	97,920,320	2,979,211,184
Wyoming	214,619,085	95,752	214,619,085	17,846,283	232,465,368
TOTAL	$153,174,488,687	$8,051,545,454	$153,424,178,545	$7,601,706,245	$161,025,884,790

Source: Forms CMS-64 as submitted by states for FY 2003. CMS Adjustments not included. Territories ceiling limit adjustments are not included.
Excludes Medicaid SCHIP Expansions, Medicaid Vaccines for Children Program, and ADM for Medicaid State Survey and Certification and Medicaid State Fraud Control Units
1/04/2005
FY03Medchart.xls

Attachment C

State	Section 1915(c) Waiver Expenditures Net of Line 19, 20, and 21 /1		Section 1915(c) Waivers FY 2003 Expenditures						Total Section 1915(c) Waiver Expenditures	
			Home and Community (Line 19) /2		Home And Community - Disabled Elderly (Line 20) /3		Community Supported (Line 21) /4			
	Total Computable (TC)	Federal Share (FS)	TC	FS	TC	FS	TC	FS	TC	FS
									Col B+D+F+H	Col C+E+G+I
A	B	C	D	E	F	G	H	I	J	K
Alabama			$208,965,761	$150,813,572	$0	$0	$0	$0	$208,965,761	$150,813,572
Alaska			$64,614,679	$51,037,753	$27,520,936	$16,381,809	$0	$0	$112,135,615	$67,419,562
Amer. Samoa			$0	$0	$0	$0	$0	$0	$0	$0
Arizona			$0	$0	$0	$0	$0	$0	$0	$0
Arkansas	$165,686	$127,959	$109,986,185	$83,384,700	$28,869	$22,362	$0	$0	$110,180,740	$83,535,021
California			$1,176,830,399	$901,928,657	$0	$0	$0	$0	$1,176,830,399	$901,928,657
Colorado			$357,944,772	$183,608,836	$0	$0	$0	$0	$357,944,772	$183,608,836
Connecticut			$445,766,980	$228,805,053	$0	$0	$0	$0	$445,766,980	$228,805,053
Delaware			$50,910,863	$26,408,800	$10,894,183	$5,447,092	$0	$0	$61,805,046	$31,855,892
Dist. Of Col.	$6,290,268	$4,514,289	$0	$0	$0	$0	$0	$0	$6,290,268	$4,514,289
Florida			$764,006,729	$461,045,577	$0	$0	$30,564	$18,266	$764,037,293	$461,063,843
Georgia	$21,470,937	$13,144,895	$195,682,199	$117,971,585	$7,790,742	$4,641,497	$0	$0	$224,943,878	$135,757,977
Guam			$0	$0	$0	$0	$0	$0	$0	$0
Hawaii			$75,617,543	$45,711,908	$0	$0	$0	$0	$75,617,543	$45,711,908
Idaho			$88,655,862	$64,321,290	$0	$0	$0	$0	$88,655,862	$64,321,290
Illinois			$503,330,419	$259,581,015	$0	$0	$0	$0	$503,330,419	$259,581,015
Indiana			$294,465,867	$187,538,010	$0	$0	$0	$0	$294,465,867	$187,538,010
Iowa			$183,373,549	$119,315,948	$0	$0	$0	$0	$183,373,549	$119,315,948
Kansas			$331,887,761	$294,436,846	$0	$0	$0	$0	$331,887,761	$294,436,846
Kentucky	$830,412	$580,375	$186,251,225	$132,886,698	$0	$0	$0	$0	$187,081,637	$133,467,073
Louisiana			$195,578,617	$142,539,562	$0	$0	$0	$0	$195,578,617	$142,539,562
Maine			$213,315,750	$144,935,255	$0	$0	$0	$0	$213,315,750	$144,935,255
Maryland			$491,792,680	$255,408,436	$0	$0	($1)	$0	$491,792,679	$255,408,436
Massachusetts	$2,138,955	$1,109,111	$618,545,393	$317,620,442	$0	$0	$0	$0	$620,684,348	$318,729,553
Michigan			$421,098,378	$241,779,820	$0	$0	$0	$0	$421,098,378	$241,779,820
Minnesota			$1,026,849,864	$528,574,156	$0	$0	$0	$0	$1,026,849,864	$528,574,156
Mississippi			$86,934,333	$67,935,709	$0	$0	$0	$0	$86,934,333	$67,935,709
Missouri	$469,496	$314,159	$507,970,295	$317,122,275	$0	$0	$0	$0	$508,439,791	$317,436,434
Montana			$55,152,907	$40,965,505	$12,480,648	$9,388,420	$0	$0	$67,633,555	$50,353,925
N. Mariana Islands			$0	$0	$0	$0	$0	$0	$0	$0
Nebraska			$151,244,355	$92,290,965	$0	$0	$0	$0	$151,244,355	$92,290,965
Nevada			$41,017,555	$21,972,096	$0	$0	$0	$0	$41,017,555	$21,972,096
New Hampshire			$148,849,083	$76,616,476	$0	$0	$0	$0	$148,849,083	$76,616,476
New Jersey			$451,062,851	$232,574,175	$0	$0	$0	$0	$451,062,851	$232,574,175
New Mexico			$222,384,097	$169,061,240	$0	$0	$0	$0	$222,384,097	$169,061,240
New York			$2,860,776,817	$1,482,270,900	$0	$0	$1	$0	$2,860,776,818	$1,482,270,900
North Carolina			$471,707,955	$301,893,082	$0	$0	$0	$0	$471,707,955	$301,893,082
North Dakota			$50,131,265	$35,393,213	$3,976,751	$2,831,881	$0	$0	$54,108,016	$38,225,094
Ohio			$756,579,953	$456,799,927	$0	$0	$0	$0	$756,579,953	$456,799,927
Oklahoma	$461,164	$330,882	$282,541,064	$203,774,270	$0	$0	$0	$0	$283,002,228	$204,105,152
Oregon	$15,388,107	$9,711,435	$555,431,469	$343,287,338	$0	$0	$29,474	$18,601	$570,849,050	$353,017,374
Pennsylvania			$1,143,235,253	$641,381,979	$0	$0	$0	$0	$1,143,235,253	$641,381,979
Puerto Rico			$0	$0	$0	$0	$0	$0	$0	$0
Rhode Island	$737,842	$408,764	$191,471,037	$109,192,658	$9,837,456	$5,449,951	$0	$0	$202,046,335	$115,051,373
South Carolina			$273,651,703	$194,924,562	$0	$0	$0	$0	$273,651,703	$194,924,562
South Dakota			$68,515,419	$45,997,211	$0	$0	$0	$0	$68,515,419	$45,997,211
Tennessee			$195,655,064	$129,406,796	$0	$0	$0	$0	$195,655,064	$129,406,796
Texas			$876,782,555	$540,090,050	$248,024,940	$152,903,126	$0	$0	$1,124,787,495	$692,993,176
Utah			$112,770,863	$82,079,289	$0	$0	$0	$0	$112,770,863	$82,079,289
Vermont			$111,647,882	$71,724,677	$0	$0	$0	$0	$111,647,882	$71,724,677
Virgin Islands			$0	$0	$0	$0	$0	$0	$0	$0
Virginia	$176,453,613	$90,515,510	$349,188,469	$183,045,307	$0	$0	$0	$0	$525,642,082	$273,560,817
Washington			$544,676,303	$281,392,007	$0	$0	$0	$0	$544,676,303	$281,392,007
West Virginia			$206,758,676	$158,522,677	$0	$0	$0	$0	$206,758,676	$158,522,677
Wisconsin	$166,560	$113,077	$537,646,127	$322,957,532	$0	$0	$0	$0	$537,832,687	$323,070,609
Wyoming			$78,344,897	$49,493,492	$0	$0	($5,163)	($3,166)	$78,339,734	$49,490,326
Total	$224,613,040	$120,870,456	$19,377,379,720	$11,201,819,107	$320,554,525	$197,066,138	$54,675	$33,701	$19,922,602,160	$11,519,789,402

/1 Data from 64.9 Waiver and 64.9p Section 1915(c) Waiver Forms Net of Lines 19, 20, and 21
/2 Data from CMS-64, Line 19
/3 Data from CMS-64, Line 20
/4 Data from CMS-64, Line 21
Note: These expenditures do not include those reported under section 1115 or section 1915(b) waiver forms on lines other than lines 19, 20, and 21

Attachment D

NIRT UPL Transition Amount Summary

December 17, 2004

State	Type	Transition Period	Amount	SFY 01	SFY02	SFY 03	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08	Comments
Alabama	IH	5	$114,417,759	$114,417,758	$114,417,759	$85,813,319	$57,208,880	$28,604,440				
	OH	5	$0									Transition determination not yet finalized
	NF	5	$69,433,694	$69,433,694	$69,433,694	$52,075,271	$34,716,847	$17,358,424				
Alaska	IH	2	$18,425,617	$18,425,617	$18,425,617							
Arkansas	OH	2	$56,520,972	$56,520,972	$56,520,972							
California	IH	8	$794,515,218	$794,515,218	$794,515,218	$794,515,218	$675,337,935	$556,160,653	$436,983,370	$317,806,087	$198,628,805	
Georgia	IH	5	$0									Transition determination not yet finalized
Illinois	OH	8	$202,284,046	$202,284,046	$202,284,046	$202,284,046	$171,941,439	$141,598,832	$111,256,225	$80,913,618	$50,571,012	
	IH	8	$703,285,046	$703,285,046	$703,285,046	$703,285,046	$597,792,289	$492,299,532	$386,806,775	$281,314,018	$175,821,262	
Iowa	NF	2	$74,461,795	$74,461,795	$74,461,795							
Kansas	NF	2	$159,612,244	$159,612,244	$159,612,244							
Louisiana	NF	2	$583,333,148	$583,333,148	$583,333,148							
Michigan	OH	5	$334,510,994	$334,510,994	$334,510,994	$250,883,246	$167,255,497	$83,627,749				
	NF	5	$646,361,500	$646,361,500	$646,361,500	$484,771,125	$323,180,750	$161,590,375				
Missouri	IH	1	$0									
	NF	2	$216,507,212	$216,507,212	$216,507,212							
Nebraska	NF	8	$75,004,569	$75,004,569	$75,004,569	$75,004,569	$63,753,884	$52,503,198	$41,252,513	$30,001,828	$18,751,142	
New Hampshire	NF	5	$23,448,731	$23,448,731	$23,448,731	$17,586,548	$11,724,366	$5,862,183				
New Jersey	NF	2	$475,805,104	$475,805,104	$475,805,104							
New York	NF	5	$899,091,602	$899,091,602	$899,091,602	$674,318,702	$449,545,801	$224,772,901				
North Carolina	IH	5	$0									Did not qualify for transition
	OH	5	$0									Did not qualify for transition
North Dakota	NF	5	$36,660,807	$36,660,807	$36,660,807	$27,495,605	$18,330,404	$9,165,202				
Oregon	NF	5	$53,677,017	$53,677,017	$53,677,017	$40,257,763	$26,838,509	$13,419,254				
Pennsylvania	NF	8	$1,335,983,613	$1,335,983,613	$1,335,983,613	$1,335,983,613	$1,135,586,071	$935,188,529	$734,790,987	$534,393,445	$333,995,903	
South Dakota	NF	2	$45,416,336	$45,416,336	$45,416,336							
Tennessee	NF	2	$99,630,713	$99,630,713	$99,630,713							
Virginia	NF	1	$477,405,016	$477,405,016								
Washington	IH	1	$0									Did not qualify for transition
	NF	5	$141,036,508	$141,036,508	$141,036,508	$105,777,381	$70,518,254	$35,259,127				
Wisconsin	NF	8	$26,327,818	$507,434,429	$507,434,429	$507,434,429	$21,528,645	$17,729,473	$13,930,300	$10,131,127	$6,331,955	
Totals			$7,662,157,079	$8,144,263,690	$7,666,858,674	$5,357,485,880	$3,825,259,570	$2,775,139,870	$1,725,020,171	$1,254,560,124	$784,100,078	

Attachment E

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan.

1. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, DRG, DSH, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (ie, general fund, medical services account, etc.) For DSH payments, please also indicate if you are making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the State, local governmental entity, or any other intermediary organization.

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan.

2. Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan.

3. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

5. Does any public provider receive payments that in the aggregate (normal per diem, DRG, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Attachment F (Summary)

Funding Inquiry SPA Counts by Category

	Institutional	Non-Inst. - DBCP	Non-Inst. - DEHPG	PharmT	Total
SPA's on Second 90 Day Clock	17	5	6	3	31
Responses Withdrawn to Avoid Disapproval	17	14	2	3	36
SPA's on First 90 Day Clock	17	17	12	10	56
Clocked Stopped SPA's	24	11	15	0	50
Approved SPAs	245	94	99	70	508
Disapproved SPAs	3	5	6	4	18
Withdrawn SPAs	14	6	19	1	40
Total	337	152	159	91	739

Attachment F

Pending SPAs with Sources of Funding Inquiries

Note tabs at bottom of spreadsheet - to print all charts select 'Entire Workbook' from print options.

Institutional and Non-Institutional Services

		Status /	
State	**Type**	**90th Day**	**Description**
SPA's on Second 90 Day Clock			
MI-04-004	IH	2nd Clock 01/16/05	Effective 4/1/04, the plan is updated to include the current DRG listing, relative weight factors, length of stay factors, high and low day thresholds, wage inflation factors, and base cost reporting period used to set inpatient hospital PPS rates. The plan is under review. Existing recycling of DSH payments. RAI sent on 7/23/04. Plan is approvable-package being developed.
KY-03-023	IH	2nd Clock 01/27/05	This amendment removes the budget neutrality adjustment for psychiatric payments and adds a supplemental Medicaid shortfall DSH payment. The state recycles a significant portion of supplemental payments to non-state government owned hospitals. The state has yet to respond to questions on previous SPAs regarding the funding of state-owned hospital payments. KY-03-008 must be resolved before this SPA can be approved. In addition to pending funding questions, informal questions regarding the changes to the payment methodology were sent to the State on 1/28/04. A formal RAI was sent on 2/12/04. The State's response was received on 5/17/04 and is under review. The State's response is insufficient. Additional questions were sent by email on 5/24/04. By telephone on 5/25/04, the State Medicaid Director was informed of options to sunset or disapprove. The State indicated they are working towards sunset and will seek a meeting with CMS is early June. A meeting with State officials was held on 6/14/04. The
MI-04-005	IH	2nd Clock 02/09/05	Inpatient Hospital "Access to Care Initiative" enhanced payments. RAI to be issued. New UPL estimate needed. RAI sent on 8/13/04. RAI Received 11/12/04.
MI-04-005	OP	2nd Clock 02/10/05	Michigan Access to Care Initiative Payments - State adding a second supplemental payment for IP & OP services. Call with NIRT 8/2/04. RAI sent 8/13/04. RAI response received 11/12/04.
ND-03-010	Pers. Care	2nd Clock 02/10/05	Rates for individual and agency providers. Call with SMD week of 12/17. Approvable SPA to be submitted week of 1/3/2005. SMD made commitment 12/29 to cap daily rate at $50 a day. OSN being prepared by RO.
UT-04-013	PHY	2nd Clock 02/15/05	Physician payment enhancement. Call with RO 7/13/04. RO submitted informal questions to State re: enhanced payment concerns. Answers to informal questions received 9/2/03. Call with RO 9/14/03 to review answers. Call with State 9/27/04. RAI sent 9/27/04. RAI response received 11/17/04. Under Review. Call with RO 12/20/04. Waiting for revised state plan page from State. Approvable.
ID-04-004	IH	2nd Clock 02/21/05	Rate setting for out-of-state hospitals that perform services unavailable in-state. Informal questions sent to State on 6/28/04. Formal RAI sent on 8/30/04. Response received 11/24/04. UPL data still not received.
NY-04-	NF	2nd Clock 02/22/05	Proposes to extend the rate adjustments to residential health care facilities, other than public RHCF's, for the purpose of workforce

022			recruitment and retention issues and a demonstration program to improve the quality of care for NF residents.
FL-04-010	Rehab	2nd Clock 03/01/05	Early intervention services. Adds new provider of services. RAI sent 6/2/2004. Due 8/31/2004. RO working with state to correct rematining problem areas (8/10/04). Revised pages submitted 9/1/04. Partial list of RO concerns with FL response to RAI was sent to CO for review on 9/14/04. Issues still exist and more information submitted by state coming to CO on 9/23/04. **9/30/04 RO sent list of concerns on state's RAI response. RO/CO call on 9/30/04 to determine next steps. Problems: (1)** comparability of services by state limiting coverage of children needing services violating EPSDT service requirements; **(2)** more information is needed on free choice of providers and how governmental providers are paid; **(3)** state wants to have early intervention services available to all children under age 21 rather than those between 0 and 3 years of age found eligible for such services under IDEA; and **(4)** rates for these services have not been adjusted since 1991. Response to RAI to be withdrawn on 10/20/04. 12/10/
IN-03-030	NF	2nd Clock 03/02/05	Response receive 12/2/04. Quality Assessment Fee and changes to NF rates to reimburse Medicaid cost of tax. RAI sent 12/8/03.
WI-03-011	NF-ICF/MR	2nd Clock 03/06/05	The State's annual revision of its NF & ICF/MR reimbursement methodologies. A RAI including the funding questions was sent on 12/22/03. Response received 3/17/04. Supplemental payments to non-state government NFs are financed with short-term bank loans. A disapproval package is in clearance. Discussed unsetting with Medicaid Director on 6/3/04. MD indicated her willingness to withdraw the RAI response so that sunset language can be negotiated. Further discussions to be held week of June 7. State withdrew RAI response on 6/3/04. Call scheduled with State on 6/15/04. Resubmitted 12/7/04 with sunset language. Reviewing.
PA-04-003	NF	2nd Clock 03/08/05	Revises definition of Medicaid eligible day
OR-04-008	CM	2nd Clock 03/09/05	Proposes to add early intervention/early childhood special education TCM to the State plan. Prep of IFSP under IDEA. RAI issued 9/10/04. RAI response received 12/9/04.
AK-04-005	CM	2nd Clock 03/10/05	Proposes to add TCM for infants and toddlers at risk for or currently experiencing developmental delays or with disabilities who are eligible for Alaska Infant learning Program services. Case management is covered as administrative costs of IDEA. Awaiting OCD decision (8/13/04). RAI issued 9/10/04. Response to RAI contending that early intervention/care coordination services under IDEA are properly CM.
MA-04-008	IH	2nd Clock 03/12/05	Modifies pediatric DSH program to provide SDH payments to privately owned, non-acute hospitals that serve pediatric patients. RAI sent 9/27/04. Response received 12/13/04. Approval package being prepared.
ID-04-005	IH	2nd Clock 03/13/05	Changes the index source used for calculating hospital inflation rates. RAI sent 9/16/04. Response received on 12/14/05.
OR-04-009	SBS	2nd Clock 03/15/05	School-based services - adding psychological, mental health evaluations and treatment. Cost-based reimbursement methodology for school-based services. Call with State 8/10/04. Reimbursement methodology acceptable. No CPEs but will be year-end reconciliation as rates based on cost. SPA language to be revised by State. RAI sent 9/17/04. RAI response received 12/15/04.

OR-04-009	Rehab	2nd Clock 03/15/05	Proposes school based rehabilitation services identified in a an IEP or IFSP. Services to be provided are: physical, occupational and speech therapies;audiology evaluations; nursing services; and mental health testing and services provided by medical professionals (i.e., physician, psychiatrist, MH nurse practitioner, and psychologist). Reassigned to FCHPG(8/2/04). Awating OCD decision (8/13/2004) to disapprove. RAI issued 9/17/04. Response received 12/17/04.
ME-03-009	NF	2nd Clock 03/16/05	Removes problematic section that would implement a new supplemental payment to County owned NFs. The plan removes return on equity, permits Medicare rates to exceed the lowest semiprivate room rate and clarifies amortization language.
CA-03-024	SBS	2nd Clock 03/16/05	Proposes reimbursing for school based services based on a cost-based prospective fee schedule. Issues around CPE and rates. RAI sent 9/25/03. RAI response received 1/21/04. Calls with State 2/24/04 and 3/24/04. Disapproval package prepared. State withdrew RAI response 4/6/04. Call with State 7/14/04 to review reconciliation process. RAI response received 12/16/04.
NY-04-026	IH	2nd Clock 03/24/05	GME reimbursement for non-public general hospitals.
NY-04-027	IH	2nd Clock 03/24/05	GME reimbursement.
IA-04-007	IH	2nd Clock 03/27/05	Effective July 1, 2004 provides for an enhanced payment for state-owned hospitals with over 500 beds, and removes a requirement for the PRO to verify one case every 6 months per facility. RAI sent 9/30/04. RAI received 12/27. Under review.
NJ-04-010	NF	2nd Clock 03/27/05	Creates new supplemental NF payments using proceeds from new NF provider tax. NJ also recycles- State will need to do sun-set.
PA-04-004	NF	2nd Clock 03/28/05	Creates new peer groups
KS-03-029	NF	2nd Clock 03/28/05	Reduces ICF/MR rates by 2.5% effective 1/1/04. Proposes to allow the State Department Director to change ICF/MR rates at will for budgetary purposes. RAI sent on 3/11/04. The State's response is under review. Potential public notice/effective date issues. The amendment still contains unacceptable "subject to available funding" language. A conference call is being scheduled with the State for the week of 8/2/04 to discuss the issues. A disapproval package is being prepared. The State informed CMS on 8/5/04 that this amendment would be withdrawn in total. On 8/13/04 the State informed CMS that it would like to try to salvage this SPA. The State withdrew its RAI response and is working on comprehensive language problems. RAI response resubmitted on 12/28/04. Effective date changed to 1/1/05. Response is under review.
NC-04-006	Rehab	2nd Clock 03/28/05	Adjusts mental health payment rate methodology; eliminates the current settlement process for service costs; and adds a cost settlement process for system mangement fees to begin 7/1/2004. Problemmatic: appears to cover services in juvenile justice facilities and IMDs. (As of 8/25/04). 9/23/04 Draft RAI in circulation among CMS for review. Working closely with state to resolve open issues, 11/17/2004. 12/29/04- State's response to the RAI received 12/28/2004 and is under review.

PA-04-010	PHY	2nd Clock 03/29/05	Mcare Abatement - Proposes a medical malpractice supplemental fee for each physician procedure, not to exceed what Medicare would pay for that particular service. Payment is not linked to a direct service. Call with RO 7/22/04. Call with State 9/1/04. Call with OGC 9/16/04. RAI sent 9/30/04. RAI response received 12/29/04.
Responses to RAI withdrawn to avoid disapproval			
AK-03-003	IH	Response Withdrawn	Revises the Optional Payment Methodology for Small Facilities. Funding questions sent on August 12, 2003. State responded on September 11, 2003. State withdrew September 11, 2003 and November 19, 2003 responses to our RAIs. CMS is talking with the State about action to move forward on this SPA.
AR-04-005(b)	PHY	Response Withdrawn	Increase in Medicaid reimbursement rate paid to physicians in the CMS program. RAI sent 6/22/04. State withdrew RAI response.
CA-03-032	OP	Response Withdrawn	Enhanced payments to private trauma hospitals up to level of available funds. RAI sent 12/23/03. RAI response received 7/30/04. Met with State 10/7/04 to review UPL demo. CMS to follow up with question on facility reimbursement for OP trauma services and request for more information on calculation of weighted Medicare fee schedule reimbursement. State withdrew RAI response 10/22/04 in order to gain additional time to work with CMS on outstanding issues.
CO-02-014	OP	Response Withdrawn	Supplemental payment provision to reimburse outpatient hospitals for Medicare Patient-Related Adjustments to Expenditures. Standard funding questions sent on 8/7/03. Call with State 6/2/04. State to send in initial UPL 6/16/04 - have not yet received. 10/20/04 - State asked for additional month to work on UPL calculation.
CO-02-013	IH	Response Withdrawn	Supplemental payment provision to reimburses hospitals for Medicare Patient-Related Adjustments to Expenditures - Response to RAI incomplete, follow-up questions sent to State on 7/2/03. On 8/7/03 the letter asking the comprehensive funding questions was sent. State withdrew its original RAI response on 8/11/03.
DC-03-007	Reha b	Response Withdrawn	Adds substance abuse program services under the rehabilitation benefit. RAI sent 11/13/2003. RAI response received 1/30/04. Call with RO 3/10/04. To be approved, if DC issues public notice week of 3/22/04. State withdrew RAI response to RAI on 3/26/04.
IA-03-017	PHY	Response Withdrawn	Supplemental payment for physician services provided to Medicaid recipients by participating physicians at qualifying hospitals. adjustment to publicly owned acute care teaching hospitals for physician services. RAI w/standard funding questions sent 11/13/03. RAI response received 2/6/04. Call with RO 2/26/04. Call with State 3/16/04. Additional info. received from State on 3/29/04. State withdrew RAI response 4/23/04. Calls with State 5/25/04 and 6/21/04. State to submit new payment methodology.
IA-03-012	IH	Response Withdrawn	Clarifies DRG reimbursement methodology language. Has a $0 Federal budget impact. Supplemental payment provision in another section of the State plan. A request for additional information, including the funding questions, was sent on 10/23/03. State's response received on 12/16/03 and is under review. The State is recycling DSH, Medical Education, and UPL payments. A disapproval package is being prepared. Disapproval package sent to OGC on 2/25/04. Disapproval package forwarded to OA.

IA-03-023	NF	Response Withdrawn	Revises inflation and occupancy factors. Also revises incentive factors based on performance. A RAI, with funding questions, was sent on 12/16/03. Response received on 3/1/04 and is under review.
IL-03-008	NF	Response Withdrawn	Revises the nursing component of the NF rate to use MDS data effective 7/1/03. A RAI with the funding questions was sent on 11/12/03. The State's response was received on 2/10/04. The State's response was incomplete. A conference call was held on 3/18/04. An email requesting additional information was sent on 3/19/04. A disapproval package was put in clearance on 4/13/04. The State withdrew their response to the RAI to allow time for additional information and discussions.
IL-03-017	IH	Response Withdrawn	Effective 10/1/03, this amendment would reclassify certain DSH payments as inpatient hospital payments. Informal questions were sent to the State on 2/18/04. A request for additional information was sent to the State on 3/11/04. The State's response was received on 6/10/04. The State's response was insufficient. A conference call was held with the State on 7/6/04 in which the State agreed to supply additional information. A conference call was held with the State on 7/22/04 in which the State agreed to supply additional information. A disapproval package was sent to OGC for clearance on 8/5/04. A conference call is scheduled with the State on 8/30/04.
KY-03-021	Other	Response Withdrawn	Will add a section describing coverage of preventive and remedial public health services through a cooperative agreement with Kentucky Dept. of Public Health. RAI sent 12/18/03. RAI response received 5/5/04. Call with State 6/10/04. Submitted additional questions to the State 6/15/04. Call with State 7/6/04. State withdrew RAI response 7/15/04.
KY-04-003	SBS	Response Withdrawn	Changes the pricing methodology for EPSDT screening conducted by enrolled providers. The changes are the result of newly implemented HIPAA measures requiring the conversion of EPSDT local procedure codes to a uniform set of procedure codes. Call with State 5/20/04 - State uses CPEs as funding source for SBS but does not reconcile rates to costs. State has asked that an RAI be issued to give them time to either change their funding source or establish a new reimbursement methodology. RAI sent 6/10/04. RAI response received 9/3/04. Call with State 10/4/04. Awaiting additional material from State (cost reports, instructions). Received cost reports from State. Call with RO 10/27/04. Additional questions sent to state 11/8/04. State withdrew RAI response 11/29/04.
MA-03-021	OP	Response Withdrawn	Updates the methods used to determine rates of payment for acute outpatient hospital services. Call with State 2/11/04. RAI sent 4/2/04. RAI response received 7/1/04. Internal mtg. 8/12/04. Call with State 8/17/04. Disapproval package in clearance. State withdrew RAI response 9/22/04.
MA-03-020	IH	Response Withdrawn	Revises payment methodology for acute inpatient hospital services and would create two new supplemental payments. RAI with funding questions issued 03/04/04. Response received 6/3/04. Conf. Call with state on 8/3/04. State failed to provide assurances that hospitals retain supplemental payments/DSH funds. On 8/6, State advised of options if assurances not forthcoming: disapproval, withdraw RAI response, or approve with sunset. Disapproval package to PCPG 8/26/04.

MI-04-002	SBS	Response Withdrawn	Adds licensed practical nurses to school based rehab services. Call with State 5/6/04 - State uses CPEs as the funding source for SBS but does not reconcile to costs. State has asked that we issue an RAI to permit them time to either change the funding source or to develop a cost-based reimbursement methodology. RAI sent 6/10/04. RAI response received 9/2/04. State wants to sunset current methodology. Call with State 12/3/04. State withdrew RAI response 12/6/04.
MN-03-015	NF	Response Withdrawn	Increases the per diem by $5.56 for NFs under PPS, reduces number of days rate enhancement will be paid for newly admitted residents, and freezes the operating rate for PPS facilities at the June 30 rate. Response received 12/23/03. Disapproval prepared. SPA outcome possibly related to outcome of SPA 03-006.
MO-04-001	IH	Response Withdrawn	Effective 3/2/04, specifies trend indices, modifies reimbursement methodology for new hospitals and hospitals that have changed ownership, and provides for trauma add-on payments and trauma outlier payments. The plan is under review. Request for addition information, including the funding questions, sent to the State on 6/28/04. Issues with UPL and how the state counts current supplemental payments. State has been informed that CMS will disapprove unless they withdraw the SPA. State indicated that they will withdraw (conference call on 12/22). We will work with state to develop UPL data that is acceptable.
NC-03-006	NF	Response Withdrawn	Provides supplemental payments to NFs and ICFs/MR Disapproval package is in clearance -- Conference call with the State 1/30/04
NY-02-014	CM	Response Withdrawn	Awaiting official State sign off on agreed to changes to SPA since 5/17/2004. State has not responded as of 5/26, therefore, disapproval package prepared and sent to PCPG on 5/26/2004. State withdrew RAI response 6/1/2004.
NY-03-031	OP	Response Withdrawn	SPA applies to payments to outpatient hospital and comprehensive diagnostic and treatment center services. Increases an approved provider tax from 5.98 percent to 6.47 percent. Standard funding questions sent on 8/28/03. RAI response received 11/28/03. State answered standard funding questions. Call with State 1/14/04. Awaiting more info. from State on funding. State withdrew RAI response 2/20/04.
NY-04-003	Clinic	Response Withdrawn	Non-Institutional Comprehensive Diagnostic and Treatment Center Indigent Care Program. Call with State 5/5/04. RAI sent 6/25/04. RAI response received 8/17/04. Under review. Waiting on decision on NIRT SPA 04-005. State withdrew RAI response.
NY-03-008	IH	Response Withdrawn	Increases payment rates for general hospital inpatient services to reimburse tax on net Medicaid-patient service revenues from 5.98% to 6.47%. RAI sent on 8/26/2003. Response to RAI received 11/24/03. State answered funding questions, but was not able to assure that providers retain funds. 2/20/03, State withdrew amendment to avoid disapproval action.
NY-04-005	IH/DSH	Response Withdrawn	Makes technical clarifications to plan and authorizes the inclusion of hospital-controlled diagnostic and treatment centers in the calculation of dsh payments. RAI responses received on 8/17/04. Disapproval package forwarded to OGC.
TX-03-019	Other	Response Withdrawn	Adds language that documents the authority of the Texas Health & Human Services Commission to adjust rates in accordance with state or federal law or due to economic conditions that prevail among providers within a specific program or category of providers.

			RAI sent 11/13/03. RAI response received 2/3/04. Call with RO 2/10/04. Additional funding info. needed from State. State withdrew RAI response 3/29/04. 5/21/04 - RO discussed options with State. No response from State as of 11/17/04.
TX-04-010	PHY	Response Withdrawn	Provides for supplemental payments for services provided by physicians and dentists who are members of practice plans affiliated with a state academic health system. Under review. Call with State 8/19/04. State to revise SPA pages. Funding issue - state is unclear if state share comes from appropriation or IGT. RAI sent 9/20/04. RAI response received 10/26/04. Under review. Call with State 12/2/04. State withdrew RAI response 12/15/04.
TX-03-019	IH/OH/LTC	Response Withdrawn	Provides that the Medicaid Agency has the authority to set rates due to changes in economic conditions effective 9/1/03. A RAI with the funding questions was sent on 11/13/03. The State's response was received on 2/3/04. The State's response is under review. A conference call was held with the State on 3/18/04. The State agreed to split the SPA between institutional and non-institutional services and make requested language revisions. The State withdrew their response to the RAI on 3/26/04 in order to work with CMS on the outstanding issues.
VA-03-005	SBS	Response Withdrawn	School Based Services. Provides for coverage of additional services. RAI sent 12/1/03. RAI response received 3/2/04. State withdrew RAI response 4/30/04. State submitted draft cost-based methodology 5/28/04. Call with State 6/10/04. Methodology not acceptable.
VT-03-008	IH	Response Withdrawn	Revises the base rate for individuals ranging in 22 to 64 population residing in the Brattleboro Retreat psychiatric hospital. Payment for the 22 to 64 population is permitted under 1115 authority. Supplemental funding questions issued 09/15/03. Response to RAI received on 10/28/03. Spoke w/ State Medicaid director on 1/20/04. The State withdrew its response to the RAI on 1/23/04. VT SPA (03-008) revises the payment to an 1115 waivered population (22-64 IMD population). A SPA will probably is not required because the terms and conditions are detailed under their 1115 demonstration. CMS will address State's concerns by revising the protocol in waiver. State to withdraw SPA b/c changes will be addressed in waiver.
WA-03-011	IH	Response Withdrawn	Revises methodology for IH payments. RAI response received 3/11/04. Disapproval package being prepared based on bad funding for this section and connection with SCHIP funding. Call scheduled for 5/20/04 regarding possible sunset provision. Disapproval package in OGC. Response withdrawn on 6/2/04.
WA-03-020	NF	Response Withdrawn	Revises methodology for NF payments to reimburse tax. RAI Response received on 3/9/04. Tax waiver still under review. Call with the State on 5/14/04 and one scheduled for 5/20/04 regarding possible sunset provision. Disapproval package in OGC. Response withdrawn on 6/2/04.
WA-03-027	IH	Response Withdrawn	Revises reimbursement for newborn screening tests.
WA-03-028	IH	Response Withdrawn	175% DSH SPA. Revises the DSH distribution methodology. State is developing sunset proposal related to DSH in another SPA. The State to withdraw RAI responses by 7/20/04 to have more time to complete sunset. Responses withdrawn on 7/22/04.
SPA's on First 90 Day Clock			

NC-04-014	NF	1st Clock 01/30/05	Maintains return of equity in PPS rates.
NC-04-013	Pers. Care	1st Clock 01/30/05	Contracts with public and private non-medical institutions eliminating cost settlements with adult care P.C. services providers. 12/2- RO recommends approval; to send funding questions 12/7/04. Funding questions sent to state via email on 12/8/04. 12/16/04- Response to funding questions received on 12/15 and sent to CO for reveiw. Draft OS Notification has been prepared. State sent additional informal questions 12/20/04 via email. 1/5/05- Still awaiting states response to questions.
VA-04-012	NF	1st Clock 02/03/05	Fair rental value
AZ-04-011	Reha b	1st Clock 02/08/05	Audiology services for children.
NC-04-011	Reha b	1st Clock 02/14/05	Adds professional mental health providers under "other licensed practitioners." This is part of NC MH reform. 12/10 - RO comments to CO on 12/2; RO finds SPA not approvable as submitted, waiting for CO comments before contacting the SMA. 12/22- RO waiting fro comments/concurrence with RO's concerns on this SPA. RO will follow up with CO to see where they are in this process. 1/6/05 - RO still waiting to hear from CO on what direction to take with the SPA.
SD-04-006	IH	1st Clock 02/15/05	Effective January 1, 2005, this SPA reduces the rate to out-of-State hospitals. Will be recommended for approval during week of 12/6/04. Once SD responds to the 04-005 questions both 04-005 and 04-006 will simultaneously be recommended for for approval.
SD-04-005	IH	1st Clock 02/15/05	Effective October 1, 2004, implements a new grouper for fy '05 which provides for a slight increase to the target rate.
MI-04-017	Othe r	1st Clock 02/16/05	Vaccine Replacement program.
MI-04-016	Clinic	1st Clock 02/20/05	Public Dental Clinic Services.
TX-04-009	Dise ase Mgm t.	1st Clock 02/21/05	To add a disease management program under preventive services in its state Medicaid plan.
NH-04-007	IH	1st Clock 02/28/05	Effective October 14, 2004, implements a decrease the state's Medicaid catastrophic claim fund from 7% of IH costs to 5% of IH cost.
IN-04-008	Othe r	1st Clock 02/28/05	Technical correction to clarify plan language of Medicare crossover processing methodology in place since July 2002.
MT-04-007	CM	1st Clock 02/28/05	Payment for CM services for youth under 21 years of age with substance abuse or dependency. CO and RO reviewing. Will follow up with call week of 1/9/05.
MT-04-009	CM	1st Clock 02/28/05	Payment for CM services for adults 21 years of age or older with substance abuse or dependency. CO and RO reviewing. Will follow up with call week of 1/9/05.
WV-04-005	IH	1st Clock 03/03/05	Increase payments to safety net providers & rural classifications

MN-04-024	NF	1st Clock 03/06/05	Effective for services on 10/1/04. Revises the methodology for Tribally-owned or operated NFs.
LA-04-022	FQHC/RHC	1st Clock 03/06/05	Increases FQHC allowable visits and revises the reimbursement methodologies for FQHCs.
LA-04-023	TRAN	1st Clock 03/06/05	Changes to NEMT services and providers.
AR-04-015	IH	1st Clock 03/08/005	Effective 12/3/04, the plan is being amended to remove the $150,000 cap for organ transplants. The plan is under review.
SC-04-009	EPSDT	1st Clock 03/08/05	Adds family members to allow them to receive reimbursement for private duty nursing and as personal care attendant. 12/10/04 call with RO to discuss and plan for next steps. 12/22/04- An internal call will be held in the next week or so. 12/29/04- RO and CO still reviewing. Call held 1/11/05. RO will follow up with state re: concerns.
NY-04-045	Clinic	1st Clock 03/09/05	Non-institutional services, methadone treatment services - diagnostic and treatment centers.
LA-04-021	IH	1st Clock 03/10/05	Effective 10/1/04 this amendment clarifies qualifications for teaching hosptials and GME payments. An approval package is being prepared.
FL-04-031	OP	1st Clock 03/10/05	Reduces outpatient reimbursement rate.
NY-04-044	NF	1st Clock 03/16/05	Adjust rates for financially disadvantaged residential health care facilities
GA-04-018	IH	1st Clock 03/17/05	Revision to DSH distribution.
SC-04-008	IH/OH	1st Clock 03/20/05	Annual updates to rate methodology.
SC-04-008	OP	1st Clock 03/20/05	Updates base year cost reports used for DSH qualification, FFY 2005 DSH payments and intermim FY 2005 Medicaid inpatient and outpatient cost settlements; updates swing bed and administrative day rates, updates SC small rural public hospital listing, and considers SC Medicaid claims volume of out of state hospitals during DSH qualification.
NC-04-015	HH	1st Clock 03/21/05	Ensures compliance by mandating reimbursement for DME/Orthotic/Prosthetic for people 21 and older. 12/29- under review.
GA-04-013	Disease Mgmt.	1st Clock 03/22/05	Operate enhanced primary case management as a voluntary disease management program. 12/29- under review. 1/05/05 - RO will discuss with CO later this week. Still under review.
NE-04-007	Other	1st Clock 03/23/05	Enhanced payment for dental services
MI-04-020	IH	1st Clock 03/28/05	Effective for services on 10/1/04. Revises the GME methodology.

LA-04-025	OP	1st Clock 03/28/05	Amends the reimbursement methodology for OP surgery services to comply with HIPAA requirements.
OH-04-011	CM	1st Clock 03/28/05	MR & DD populations
OH-04-015	Rehab	1st Clock 03/28/05	Reimbursement for habilitation.
NJ-04-011	NF	1st Clock 03/29/04	Moves supplemental payments in regular rates, i.e., rather than paying supplemental payments, the State will just pay higher daily rates.
KS-04-011	IH	1st Clock 03/29/05	Routine annual adjustment to DRG weights and rates effective October 1, 2004. The plan is under review.
KS-04-012	IH	1st Clock 03/29/05	Effective January 1, 2005, increases indirect medical education payments. The plan is under review.
FL-04-032	OP	1st Clock 03/29/05	This amendment implements the reimbursement by Medicaid for revenue code 510, Clinic/General, in accordance with the Medicaid Outpatient Hospital Coverage and Limitations Handbook, for health care services, in outpatient clinic facilities where a public hospital assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Dept. of Health or the local county government.
WA-04-013	OP	1st Clock 03/29/05	Outpatient Prospective Payment System (OPPS) - Implementation and replacement of the inpatient-outpatient 24-hour rule.
TX-04-029	PHY	1st Clock 03/30/05	Provides supplemental payments for services provided by doctors of medicine and osteopathy and dentists employed by or under contract with a non-state owned or operated publicly-owned hospital or hospital affiliated with a hospital district in Tarrant County.
TX-04-033	Other	1st Clock 03/30/05	Revises reimbursement methodologies for ambulatory surgical centers (ASCs), hospital-based ASCs and birthing centers to include an add-on payment for high-volume service providers.
MA-04-016	OP	1st Clock 04/04/05	Methods used to determine rates of payment of Acute outpatient hospital services.
MA-04-018	Other	1st Clock 04/04/05	Community Health Centers/Federally Qualified Health Centers - prospective rate increase.
MA-04-019	PHY	1st Clock 04/04/05	Physician payment rates.
UT-04-020	TCM	1st Clock 04/04/05	Defines counties for TCM for adults with MI and children with SED.
Clocked Stopped SPA's			
AK-04-009	IH	Clock Stopped	Inpatient payment rate update. There are concerns over the State's funding that will be addressed through this SPA.
AZ-04-003	OP	Clock Stopped	New outpatient fee schedule methodology. RO/CO meeting 5/27/04. Call with State 6/15/04. State told to submit UPL calculation. 7/1/04 - Charlene agreed to let State to submit separate SPA prior to the receipt of the UPL demonstration to stabilize rates

			effective 7/1/04. RAI sent 7/19/04.
CA 04-008	CM	Clock Stopped	Public guardian- updates geographic areas. Per CMS management, RAI's to be preparee and further negotiations initiatied with the state. Concerns linked to previously disapproved SPA, 03-028b. RAI issued 12/22/2004. Due 3/22/2005.
CA-04-004	CM	Clock Stopped	Redefines criteria for lead poisoned children. Per CMS management, RAI's to be preparee and further negotiations initiatied with the state. Concerns linked to previously disapproved SPA, 03-028b. RAI issued 12/22/2004. Due 3/22/2005.
CA-04-006	NF	Clock Stopped	Cost of living adjustment for freestanding SNF.
CA-04-007	CM	Clock Stopped	Public health, outpatient and frail elderly- Updates geographic areas. Per CMS management, RAI's to be preparee and further negotiations initiatied with the state. Concerns linked to previously disapproved SPA, 03-028b. RAI issued 12/22/2004. Due 3/22/2005.
CA-04-009	CM	Clock Stopped	Adult probation- updates geographic areas. Per CMS management, RAI's to be preparee and further negotiations initiatied with the state. Concerns linked to previously disapproved SPA, 03-028b. RAI issued 12/22/2004. Due 3/22/2005.
CT-04-007	IH	Clock Stopped	Effective 8/1/2004 revises the DSH payment methodology for hospitals serving low-income persons. RAI sent 11/26/04.
FL-04-029	TCM	Clock Stopped	Children's Health Services Targeted Case Management. 10/28- RO waiting on guidance for unapprovable SPA. Memo sent to CO on 10/18/04. 11/04/04 - Complex SPA realted to a pending Administrative Claiming Proposal. RO intends to send 2nd memo on issues to CO later this week, further clarifying our need for technical assistance. Teacher as CM in IEP. Same as FL 03-24 which was disapproved. Admin Cost Allocations part of SPA to be approved with conditions for state to comply with no later than 3/31/05 or funding will be suspended. Additionally, an RAI to be issued concerning the coverage and payment issues. Both of these documents will be issued during the week of 12/12/04. RAI issued 12/9/04. Due 3/9/05.
FL-04-25	Rehab	Clock Stopped	Proposes to eliminate requirement that the school-based services--nursing and behavioral, be referenced in the student's IEP in order to be Medicaid reimbursable. RAI to be issued. (FCHPG has lead). RAI issued 11/8/04.
GA-04-006	OP	Clock Stopped	Change in payment methodology for outpatient hospital services - want to reduce OP rate. Call with RO 7/28/04. Informal questions sent to state. Call with State 9/9/04 to discuss UPL information and other issues. RAI sent 9/30/04.
GA-04-007	PDN	Clock Stopped	PDN under EPSDT, would provide continuous skilled nursing services. Payment: lower of charges or statewide rate. Awaiting state final decisions and changed pages (as of 8/19/04). 9/29/04 Awaiting imput from CO before approval. RAI to be issued by 10/29/04. RAI issued 11/2/04.
IA-03-024	NF	Clock Stopped	Adds a quality assurance payment to be funded by an assessment collected from non-governmentally owned or operated NFs. A RAI, including the funding questions, was sent on 3/5/04. State requested on 5/19/04 additional time to respond to RAI while they

			perfect their waiver structure for the tax.
IA-04-013	NF	Clock Stopped	Effective 7/1//04 this amendment adjusts allowable cost calculations by HCFA/SNF index and reduces excess payment allowance calculations. RAI sent 12/22/04.
IL-04-006	IH	Clock Stopped	Effective 4/1/04 amends critical hospital access payments (CHAP). The plan is under review. A RAI was sent on 8/3/04.
IL-04-007	NF	Clock Stopped	Effective 4/1/04 amends the alternative payment methodology for county nursing facilities. The plan is under review. A RAI was sent on 8/3/04.
IL-04-011	NF	Clock Stopped	Effective 7/1/04 this amendment increases rates to nursing facilities and revises the capital rate. The rate increase is conditioned upon CMS approval of hospital tax and waiver. A RAI was sent 11/3/04.
IN-04-007	NF	Clock Stopped	Effective 7/1/04 this amendment revises rates to religious non-medical institutions.
KS-04-005	Rehab	Clock Stopped	Community mental health services provided to children in adoption services, juvenile detention and foster care. Under review by RO. RAI to be sent. Will change providers to PRTFs. Rewritten RAI sent to RO 12/21/04. (Draft RAI sent to CO on 12/21/04.) RAI issued 12/23/2004. Due 3/23/2005.
KS-04-006	IH	Clock Stopped	Effective 7/1/04 this amendment establishes new inpatient reimbursement to reflect the proceeds from a new provider tax. RAI sent on 12/14/04.
KS-04-006	OP	Clock Stopped	DRG provider assessment. Establishes new inpatient and outpatient payment adjustments. Provider tax issue - appears to be violation of hold harmless arrangement. RAI sent 12/14/04.
KS-04-010	IH	Clock Stopped	Effective 7/1/04 this amendment modifies the calculation of DSH patients. It is a budget neutral amendment. RAI sent 12/10/04.
KY-04-005	NF	Clock Stopped	Effective 7/15/04 this amendment increases rates for price-based nursing facilities. Informal questions were sent to the state on 10/6/04. A RAI was sent to the state on 12/13/04.
LA 04-017	HH	Clock Stopped	To amend reimbursement methodology for artificial eyes and related services and diabetic equipment and supplies. RO preparing approval package (11/22/04). RAI issued 12/23/2004. Due 3/23/2005.
LA-04-015	IH	Clock Stopped	Effective 8/15/04 requires that rural hospitals be certified by the Rural Hospital Coalition in order to receive DSH payments under the rural hospital DSH methodology. Additional information will be requested from the State. A RAI was sent to the state on 12/16/04.
LA-04-016	SBS	Clock Stopped	Changes to school-based methodology in EPSDT program. RAI sent 12/22/04.
MA-04-008	IH	Clock Stopped	Revises Pediatric DSH program to provide DSH payments to privately owned non-acute hospitals that service pediatric patients
ME-04-014	Pers. Care	Clock Stopped	Amends personal care services in residential setting. 11/15 - Conferenced with the state. Awaiting the states follow- up to several questions. RAI to be issued 12/9/04. RAI issued 12/16/04. Expires 3/16/05.
MI-04-002	SBS	Clock Stopped	Adds licensed practical nurses to school based rehab services. Call with State 5/6/04 - State uses CPEs as the funding source for SBS but does not reconcile to costs. State has asked that we issue an RAI to permit them time to either change the funding. RAI issued

			6/10/2004. Due 9/18/2004.
MI-04-010	IH	Clock Stopped	Effective 7/1/04 this amendment updates the GME weighting factors and implements change in payment schedule. RAI sent 12/22/04.
MN-04-015	IH	Clock Stopped	Medical Education amendment. This amendment is a follow-up to SPA 03-039. There will be issues concerning the funding and structure of this pool.
MN-04-018	NF	Clock Stopped	Methods and standards for determining payment rates for services provided by NF
MO-04-016	NF	Clock Stopped	Effective 7/1/04 this amendment rebases nursing facility and HIV nursing facility reimbursement rates each fiscal year. RAI sent 12/23/04.
MS-04-004	HH	Clock Stopped	Revises coverage language to provide: (1) up to 60 visits per year; (2) medical supplies through home health agencies; and (3) aide services without requiring skilled services. 9/16/04 CO provided RO with recommendations and will contact state re: minor concerns. RO received response to RAI 10/8/2004. Call with MS on 10/20/04. RAI to be issued. RAI issued 10/25/04.
MT-04-010	NF	Clock Stopped	RAI sent on 12/27/04. Effective 7/1/04, implements an inflationary increase to NFs and reduces rates to ICF/MRs. Revised response and pages are under review.
NC-04-002	OP	Clock Stopped	Adds a provision authorizing DSH payments up to 175% of the hospital specific limit for hospitals operated by the Univ. of NC. Eliminates language requiring settlement of enhanced and DSH payments. Call with RO 4/29/04. Call with State 5/27/04. RAI sent 6/3/04.
NC-04-009	ICF/MR	Clock Stopped	State ICF/MR assessments
NC-04-012	ICF/MR	Clock Stopped	Provides prospective reimbursement for ICFs/MR
NJ-03-002	NF	Clock Stopped	Adjusts NF rate to include cost of provider tax as an allowable cost. Also provides for a uniform rate increase for all Medicaid-bed days. RAI w/funding questions sent 11/13/03. State has requested additional time to address RAI questions and tax structure issues.
NJ-04-006	IH	Clock Stopped	Modifies payments to specialized pediatric facilities--
NJ-04-008	IH/DSH	Clock Stopped	adjusts the DSH payment distribution
NJ-04-009	NF	Clock Stopped	NF supplement to those that treat high number of Medicaid
NJ-04-012	Clinic	Clock Stopped	Limitations on reimbursement for medical day care. RAI sent 12/13/04.
OK-04-006	Rehab	Clock Stopped	Payment to O/P mental health providers (residential foster care). Call with state week of 12/13 & RAI if necessary. RAI issued 12/21/2004. Due 3/21/2005.

SC-04-001	Other	Clock Stopped	Medical assistance to promote risk appropriate care for pregnant women and infants through risk assessment and follow-up. State to submit changes to language and reimbursement from 6/30/04 discussion. Funding responses received from State 7/27/04. Call with State TBA. Issue: Cost determination vs. fee schedule rate for public health departments. RAI sent 8/12/04.
TN-04-003	Other	Clock Stopped	Adds nursing services to Tennessee's School-based health program which was approved in June 2004. Also adds three types of providers to the list of providers approved to provide behavioral services. RAI sent 10/15/04.
TX-04-004	SBS	Clock Stopped	Changes to reimbursements to school-based health issues & establishing payment rates. RAI sent 12/17/04.
TX-04-015	Rehab	Clock Stopped	To provide residential rehabilitative behavioral health services for children for whom the responsibility for care and placement has been assigned to a public agency and have special needs that require more care than can be provided in a family or foster home setting. RAI issued, 12/28/2004.
TX-04-021	CM	Clock Stopped	Removes references to MRLA in CM for individuals with MR or related conditions or PDD option. Amends reimbursement methodology to include setting interim rates biennally and calculation of proforma rates in absence of historical data. 11/9/04-RO will solicit answers to informal question from state. RAI to be issued 12/10/2004. RAI issued 12/15/04. Expires, 3/15/05.
VA-04-006	IH	Clock Stopped	Modified graduate education payments
VA-04-008	IH	Clock Stopped	Freezes rebates of rates, eliminates neonatal intensive care unit payment, and enhances indirect medical education.
VA-04-010	IH/NF	Clock Stopped	This amendment adds kinetic therapy services as a covered ancillary cost. The amendment also restores language that was inadvertently deleted and continues payment reductions for outpatient capital and operating costs.
VA-04-011	Other	Clock Stopped	Increases emergency room fees. Informal comments sent to state 10/19/04. RAI sent 11/24/04.
VA-04-014	Other	Clock Stopped	Increases OB/GYN rates. Informal comments sent to RO 10/17/04. RAI sent 11/24/04.
WI-04-006	IH	Clock Stopped	Effective 7/1/04 this amendment makes changes to cost reporting , modifies DME payments, critical access payments, modifies professional services excluded from per diem rate. RAI sent 12/22/04.
WI-04-007	OP	Clock Stopped	Outpatient hospital rates. RAI sent 12/17/04.
WI-04-008	NF	Clock Stopped	Effective 7/1/04 this amendment modifies attachment D in its entirety. RAI sent on 12/23/04. Tied to 03-11 which was reactivated on 12/7/04.
Approved SPAs			
AK-03-	OP	Approved 12/17/03	Changes payment methodology for outpatient hospital - UPL and supplemental payments

004			
AK-03-008	SBS	Approved 2/2/04	Coverage and IDEA Services
AK-04-002	OP	Approved 11/04/04	Outpatient payment rate update - move to prospective payment rate.
AK-04-003	IH	Approved 10/19/04	Revises methodology for determining inpatient payment rate. Response received on July 23, 2004. Approval package prepared. Approval recommendation week of 10/1/04.
AK-04-007	Rehab	Approved 9/23/2004	The SPA indicates that it contains a technical clean-up of limitations for Rehab Services.
AK-04-008	Pers. Care	Approved 9/7/2004	Proposes to allow two state agencies to perform state authorization of of plan of care.
AK-04-010	OP	Approved 12/27/04	Outpatient payment rate update.
AL-04-001	CM	Approved 4/22/2004	CM formerly in a 1915(b) waiver.
AR-03-009	NF	Approved 01/22/04	Extends 75% minimum occupancy requirement for calculating fair market rental payment component in NF per diem rates by 1 year. Not part of this SPA, but elsewhere in Attachment 4.19-D the state has supplemental payment provisions for non-state government NFs. On 8/4/03 a RAI including funding questions was sent. The State's response to the RAI was received on 10/28/03 which indicated all but $1,000 of the supplemental payments to non-state nursing facilities is returned to the State. The State was informed by phone on 12/4/03 that 03-09 could not be approved due to the IGT arrangement. A letter was received by CMS on 12/30/03 in which the State proposes to submit a SPA by 1/30/04 that would end the supplemental payments to non-state government NFs effective 1/4/04 if CMS will approval 03-09 and not defer previous payments. A disapproval package cleared OGC on 1/12/04 and is in clearance. An approval package is being prepared to accept the State's offer.
AR-03-010	IH	Approved 11/24/03	Increases rates to 15 bed or less ICF/MRs by 3% based on CMS market basket forecast. Not part of this SPA, but elsewhere in Attachment 4.19-D the state has supplemental payment provision to non-state government NFs. On 8/4/03 a RAI including the funding questions was sent. The State's response to the RAI was received on 10/28/03. The State's response is being reviewed.
AR-04-002	NF	Approved 03/02/04	Effective 1/1/04 this amendment ends supplemental payments to non-state public nursing facilities and the State's recycling program. The amendment is under review.
AR-04-003	Other	Approved 12/13/04	Changes to reimbursement for levonorgestrel releasing intrauterine devices.
AR-04-005	PHY	Approved 11/1/04	Changes to reimbursement rates for doctors. Increases payment consistent with a court order.
AR-04-006	Rehab	Approved 9/7/2004	Change payment rates for private duty nursing.

AR-04-007	IH	Approved 06/21/04	Effective 5/1/04, "HCFA" is being replaced by "CMS" in Attachment 4.19-A. The State was sent the funding questions by email on 4/28/04. We are waiting on a response from the State. The State providing the answers to the funding questions on 6/16/04. An approval package is being prepared.
AR-04-009	Pers. Care	Approved 8/17/2004	Changes to payment methodology.
AR-04-011	Dialysis	Approved 9/23/2004	Establishes rates for peritoneal dialysis that match Medicare rates for Arkansas.
AR-04-013	IH	Approved 11/30/04	Effective 11/1/04 revises supplemental payments to non-state government owned or operated hospitals. This plan involves "the Med". Informal questions were sent to the state on 8/31/04. A RAI was sent to the State on 10/20/04. The State has a recycling problem in which non-state government hospitals IGT the state share plus 20% of payment. The State has agreed to sunset their funding arrangement on 6/30/05. An approval package is being prepared. .
AR-04-014	NF	Approved 8/17/04	Effective October 1, 2004, the capitalization requirement for group purchases and minor equipment is increased to $1,000 for cost reporting purposes. An approval package is being prepared.
AR-04-016	NF	Approved 9/14/04	Effective 7/1/04, the minimum occupancy requirement used to calculate the per diem rates to NFs is being revised. The plan is under review. An approval package is being prepared.
AZ 04-007	Other	Approved 9/10/04	Clarifies the maximum rate for the administration of vaccines in the Vaccines for Children Program.
AZ 04-008	OP	Approved 7/22/04	Proposes interim methodology, to be replaced effective 7/1/05 by methodology in pending SPA 04-003.
CA-02-018	OP	Approved 9/12/03	Provides additional reimbursement for adult day health care services and public hospital outpatient services. Local funds would be certified to obtain FFP. No new expenditures would be made by the State.
CA-03-002	IH	Approved 12/29/03	Removes "Bad debt" from the calculation of DSH payments under the OBRA 93 limits.
CA-03-018	NF	Approved 12/29/03	Proposes to freeze the previous year's reimbursement rate for long term care facilities that would otherwise have incurred a decrease in their subacute reimbursement rate.
CA-03-020	NF	Approved 12/29/03	This SPA will eliminate the DP/NF Level A 100+ bedsize category from the reimbursement methodology.
CA-03-021	NF	Approved 12/29/03	Removal of Discretionary Language of Add-Ons. Approval package being prepared.
CA-03-022	CM	Approved, 8/25/2004	Payment methodology for DD TCM group.
CA-03-025	NF	Approved 12/29/03	Proposes to pay an interim rate to the County of San Mateo for an LTC facility that it recently acquired.
CA-03-	IH	Approved 12/29/03	Implements overall rate freeze on all LTC facility services.

027			
CA-03-028A	CM	Approved 7/6/2004	Targeted case management
CA-03-039	HH	Approved 8/31/2004	Proposes to change the reimbursement methodology for DME by .8% for FFY 2004.
CA-03-041	NF	Approved 05/17/04	Revises methodology for reimbursement rates for hospice care services to providers for room and board services. Approval prepared and moved forward.
CA-04-002	IH	Approved 11/30/04	Adds methodology to reimburse out of state hospitals according to court order. Approval package being prepared.
CA-04-005	NF	Approved 12/08/04	Pagination changes
CO-03-002	HH	Approved 2/9/2004	Payment rate adjustments
CO-03-004	Other	Approved 12/30/03	Payment rates for dental services - Lesser of ADA Fee Schedule or State Fee Schedule
CO-03-005	Other	Approved 12/30/03	Payment rates for physicians, podiatrists and optometrists - Lesser of Charges, State Fee Schedule or 75% of Medicare's average allowable reimbursement.
CO-03-006	IH	Approved 01/22/04	Eliminates an administrative incentive allowance for one quarter. Supplemental payment provision in another section of the State plan. A request for information was sent 8/1/03 including the funding questions. State's response received on October 30, 2003. Approval package is being prepared. Approval package in OCD 1/21/04.
CO-03-009	IH	Approved 02/23/04	Revises the hospital reimbursement methodology to tie the Medicaid payment rates to the Medicare base rates in effect at October 1 of each year. Supplemental payment provisions in other sections of the State plan. A request for information was sent 8/29/03 including the funding questions. The State's response was received on 11/26/03 and is under review. Approval package being prepared 1/21/04.
CO-03-010	IH	Approved 1/22/04	Revises inpatient hospital supplemental payment provisions. Replaces previous Medicare UPL and Major Teaching Hospital payment provisions with new "High-Volume" and "Pediatric Major Teaching Hospital" payment provisions. These revisions will result in greater supplemental payments for government providers, freeing DSH funds to use for other hospitals. A request for information was sent 8/29/03 including the funding questions. Response received on 11/18/03. Working with State to resolve one funding issue. Funding issue resolved and approval package being prepared on 1/16/04. Approval package in OCD 1/21/04.
CO-03-011	NF	Approved 1/22/04	Revises the DSH payment provisions. The State currently expends its entire DSH allotment. This spa will result in a redistribution of DSH payments among providers. A request for information was sent 8/29/03 including the funding questions. Response received on 11/18/03. Working with the State to resolve one funding issue. Funding issue resolved and approval package being prepared on 1/16/04. Approval package in OCD 1/21/04.

CO-03-013	Other	Approved 12/30/03	Payment rates for non-physicians - Lesser of Charges, State Fee Schedule or 75% of Medicare's average allowable reimbursement.
CO-03-036	Reahb	Approved 3/26/2004	Court ordered psych.
CO-03-038	CM	Approved 6/22/2004	Revises payment methodology for Community Centered Boards.
CO-04-006	PDN	Approved 9/17/2004	Revises the limitations on the number of hours per day for PDN services.
CO-04-007	IH	Approved 8/24/04	Technical change. Reformatting of Attachment 4.19-A. The plan will go to OCD for approval.
CO-04-008	IH	Approved 8/24/04	Inpatient hospital rates for acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries. The plan will go to OCD for approval.
CO-04-010	NF	Approved 1/4/05	Effective 7/1/04 modifies payments methodology for establishing payment rates. The plan is under review. RAI sent out on 9/1/04. RAI received on 10/27/04 and is under review. Aprroval package to OCD.
CO-04-011	IH	Approved 12/15/04	Effective 10/1/04 increases the total funds available in specific DSH pools. Methodology for payment does not change. There is concern about the state's use of CPE (process needs to be defined). RAI sent out on November 3rd. Response Received 11/17/04, under review. Approval package to OCD.
CO-04-012	IH	Approved 12/21/04	Effective 7/1/2004 revises total amounts available for various DSH pools. State has responded to the funding questions. Should be approvable. There is concern about the state's use of CPE (process needs to be defined). RAI sent out on November 3rd. Response Received 11/17/04, under review. Approval package to OCD.
CO-04-013	IH	Approved 12/7/04	Effective 7/1/04, modifies inpatient hospital rates.
CT-03-009	IH/DSH	Approved 2/20/04	175% DSH for Public Acute Care Hospitals. Sent RAI w/funding questions on 10/16/03. Response received 11/24/03 under review. State responses indicated the State does not make any enhanced or supplemental payments and does not use IGT's CPE's or provider taxes. Approval package in OCD.
CT-03-012	NF	Approved 03/23/04	Changes to rates ICF/MRs and nursing facilities. RAI sent 12/8/03. Response rcv'd 03/04/04, under review. State makes no enhanced or supplemental payments and does not use IGT's, all payments stay with providers. Approval package forwarded to OCD.
CT-03-013	IH/DSH	Approved 02/17/04	Eliminates 10% low-income utilization requirement and changes definition of low-income to include GA days. RAI, with questions on DSH methodology and comprehensive funding questions sent on 8/28/03. Response received 11/24/03 under review. State responses indicated the State does not make any enhanced or supplemental payments and does not use IGT's CPE's or provider taxes. Approval package in OCD.
CT-03-014	IH/DSH	Approved 02/17/04	New provision for DSH payments for behavioral health services. Sent RAI w/funding questions on 10/16/03. Response received 11/24/03 under review. State responses indicated the State does not make any enhanced or supplemental payments and does not

			use IGT's CPE's or provider taxes. Approval package in OCD.
CT-03-016	IH	Approved 02/17/04	Changes rates for liver transplants. Sent RAI w/funding questions on 10/16/03. Response received 11/24/03 under review. State responses indicated the State does not make any enhanced or supplemental payments and does not use IGT's CPE's or provider taxes. Approval package in OCD.
CT-03-018	IH/DSH	Approved 02/17/04	Changes DSH methodology to increase payments to General hospitals in financially distressed communities. Sent RAI w/funding questions on 10/16/03. Response received 11/24/03 under review. State responses indicated the State does not make any enhanced or supplemental payments and does not use IGT's CPE's or provider taxes. Approval package in OCD.
CT-03-021	Rehab	Approved 8/31/2004	Group homes for persistent and serious mental illness and substance abuse residential treatment program added in residential group home programs of less than 17 beds.
CT-03-022	IH	Approved 02/17/04	Provides for additional DSH payments effective 1/1/04. Working w/state in conjunction with other DSH SPAs. Previous answers to funding questions are adequate. Will try to approve this SPA without an RAI. Approval package in OCD.
DE-03-099	Rehab	Approved 3/16/2004	Community support services
DE-04-001	Other	Approved 3/9/2004	Reserved beds-NFs
DE-04-002	Rehab	Approved 4/19/2004	PT, OT Speech pathology
FL-02-016	PHY	Approved 4/23/04	Provides supplemental payments to physicians and osteopaths affiliated with designated teaching medical schools. Payment is benchmarked to "commercial rates".
FL-03-006	CM	Approved 12/23/2003	Non-Foster Care children at risk
FL-03-008	IH	Approved 10/20/03	Increases supplemental payments to hospitals. Counties IGT state share of payments. It is unclear whether providers retain 100% of the payments. On 8/4/03 a letter asking the outstanding funding questions was sent. A series of calls have taken place between CMS and State officials to work through the outstanding issues. The State responded to the 8/4/03 letter on 9/5/03. The state did not provide sufficient information regarding the funding arrangements between the counties and the hospitals. On 9/8/03 the State was requested to provide contact names and phone numbers of county officials so that CMS can contact the counties directly to determine whether any improper funding arrangements exist. On 9/15/03 the state was given another set of questions to determine relationship between counties, taxing districts, and the hospitals. A disapproval package was prepared and reviewed by GC. State withdrew its response to all RAIs on 9/23/03. State has been instructed to provide information for all counties
FL-03-011	OP	Approved 11/17/03	Adult Liver Transplant Services - Change in reimbursement methodology - charges up to a global fee.

FL-03-011	ICF/MR	Approved 11/17/04	Institutes a global fee for transplant services. A request for additional information including the comprehensive funding questions was sent on 8/8/03. The State responded to the RAI on October 14, 2003. Additional questions were sent to the State on 11/5/03. The State responded on the 11/6/03.
FL-03-015	NF	Approved 1/5/03	Further increases supplemental payments to hospitals. It appeared the payments would exceed the UPL and violate effective date regulations. A request for additional information including the comprehensive funding questions was sent on 8/11/03. The State's response to the RAI was received on 10/24/03. The State response was not sufficient. A follow up email was sent the State on 11/12/03. The State responded with additional revisions on 12/5/03 that complied with the UPL requirements.
FL-03-018	IH	Approved 11/17/03	This SPA eliminates a $27 million rate increase that went into effective 7/1/02. A RAI including the funding questions was sent on 8/19/03. The State responded to the RAI on 10/15/03.
FL-03-025	IH/DSH	Approved 1/29/04	Changes the reimbursement in inpatient hospital services including DSH. An RAI with the funding questions was sent on 11/12/03. A response to the RAI was received on 12/30/03. The State was asked to provide additional revisions to plan language on 1/14/03. The State submitted the requested revisions on 1/20/04. An approval package is being prepared.
FL-03-026	OP	Approved 3/25/04	Implements changes to the outpatient hospital reimbursement methodology (ceilings and targets) in accordance with the 2003-04 FL Legislature.
FL-03-028	NF	Approved 1/22/04	This plan appears to the revise cost report submission dates and cost reporting periods for NFs. It also revises the chart of accounts for cost reports. The State has addressed the funding questions and there does not appear to be any inappropriate funding. An approval package is being prepared for clearance.
FL-04-013	NF	Approved 6/1/04	This amendment modifies the way the annual inflation factor in calculated for NF rates. An approval package is being prepared.
FL-04-014	IH	Approved 6/21/04	Sets the final amount of supplemental payments for SFY ending 6/30/04. An approval package is being prepared.
FL-04-020	NF	Approved 8/24/04	Effective 7/1/04 provides for a rate reduction to NFs. The plan is under review. An approval package is being prepared.
FL-04-021	IH	Approved 4/21/04	Effective 7/1/04 provides for annual update to supplemental payments, DSH, and per diem rates. An approval package is being prepared.
FL-04-022	OP	Approved 10/19/04	Modifies outpatient hospital reimbursement rates, ceilings and cost reports in accordance with the Florida 2004-05 General Appropriations Act.
FL-04-026	Other	Approved 11/10/04	Adds a certification in the cost report to be signed by the provider's administrator or chief financial officer regarding compliance with applicable laws and regulations.
FL-04-027	ICF/MR	Approved 9/14/04	Effective 7/1/04 revises reimbursement to government owned ICF/MRs. The plan is under review. An approval package is being prepared.
FL-04-028	ICF/MR	Approved 9/14/04	Effective 7/1/04 revises the reimbursement to private ICF/MRs. The plan is under review. An approval package is being prepared.
GA-	HH	Approved	Payment rate adjustments

03-008		11/6/2003	
GA-03-009	NF	Approved 4/06/04	Adds a case-mix adjustment to the NF reimbursement methodology. Also adds a rate adjustment for a provider tax. Supplemental payment provision in another section of the State plan. A request for additional information, including the funding questions, was sent on 10/9/03. State's response received on 1/7/04 and is under review. Tax issues. Possible withdrawal of response. State is willing to cooperate. State changed its willingness to cooperate on 3/30/04. Disapproval package in OGC as of 4/1/04. Disapproval package cleared by OGC on 4/1/04 and is in CMSO clearance. Approved on 4/6/04 with audit to be done.
GA-04-001	Other	Approved 5/27/2004	NF payment
GA-04-005	NF	Approved 9/21/04	Reduces payments to hospital-based providers. Reduces the inflation factor for all providers. Informal questions sent to State on 7/12/04 and 8/3/04. Approved with reference to ongoing OIG audit of both NF & IH funding.
HI-03-002	IH/NF	Approved 6/9/04	Revised reimbursement for IH and NF services. Responses received on 3/16/04. Approval package being prepared.
HI-03-005	Other	Approved 12/29/03	Changes in reimbursement for services related to organ transplants as being coordinated, managed and reimbursed by a contractor selected by the State.
HI-03-005	IH	Approved 12/29/03	Amendment to recognize organ transplant services.
IA-03-003	IH	Approved 03/02/04	Updates references in the plan to various CFR citations. Has a $0 Federal budget impact. Supplemental payment provision in another section of the State plan. A request for additional information, including the funding questions, was sent on 9/19/03. State's response received on 12/16/03 and is under review. The State is recycling DSH, Medical Education, and UPL payments, bit this amendment is just a technical amendment. The recycling issues are being addressed through SPA 03-012. An approval package is being prepared 2/24/04.
IA-03-005	Other	Approved 3/4/2004	NF - bed hold
IA-03-010	OP	Approved 2/20/04	Clarifies reimbursement methodology for hospital outpatient services, based on ambulatory patient groups.
IA-03-025	NF	Approved 6/28/04	Recognizes assessment fees paid by state operated ICFs/MR as an allowable cost in setting Medicaid rates. RAI sent 03/12/04. State's response received 4/8/04 and is under review. Approval package prepared 6/22/04.
IA-04-003	IH	Approved 10/7/04	Effective 1/1/04, specifies total amounts to be paid out for disproportionate share and medical education. The plan is under review. RAI sent to the State on 6/24/04. Response received on 7/9/04 and is under review.
IA-04-004	OP	Approved 11/04/04	Updates amounts allocated from Graduate Medical Education and Disproportionate Share Fund for outpatient hospital services and removes outdated PRO outlier case review information.
IA-04-005	Rehab	Approved 12/3/2004	Providers can be granted deemed status in MA prog. If they are accredited by national organizations.

ID-02-013	IH	Approved 2/20/04	Reduces interim payments to hospitals by 3.5%. Supplemental payment provision in another section of the State plan. On 8/8/03 the letter asking the comprehensive funding questions was sent. A disapproval package has been prepared. The State has indicated it might withdraw its response to the RAI. The State was given until noon on 9/5/03 to do so. The State withdrew its original RAI response on 9/5/03. The State resubmitted its response on 11/24/03. The response is under review. Approval package being prepared 1/21/04.
ID-03-005	IH	Approved 03/02/04	Revises the method of calculating interim hospital rates. Supplemental payment provision in another section of the State plan. A request for additional information, including the funding questions, was sent on 9/12/03. State's response received on 12/10/03 and is under review. Approval package being prepared 2/24/03.
ID-04-006	OP	Approved 9/23/04	Moves references to out of state hospital reimbursement to the correct location in attachment 4.19B from 4.19A.
IL-03-004	SBS	Approved 12/1/03	School Based Services - Proposes reimbursing for all school based services based on cost (currently fee schedule)
IL-03-004	Rehab	Approved 12/1/2003	School based svcs.
IL-03-006	NF	Approved 1/12/04	Increases payments to private hospitals with more than 1,500 obstetrical days. Illinois qualifies for an 8 year transition for non-state public hospitals. There is recycling of transition funds. It is unknown whether there is any-recycling beyond transition amounts. On 8/4/03 a RAI including the funding questions was sent. The State's response was received on 11/3/03. The State's response was not sufficient. An email with additional questions was sent to the State on 11/19/03. Additional information was received from the State on 12/17/03. An approval package is being prepared.
IL-03-012	IH	Approved 4/5/04	Effective 7/1/03 this SPA revises payments to county owned hospitals and provides language to limit minimum payments to comply with Federal limits. This amendment relates to payments to Cook County Hospitals. CMS is aware the State receives significant IGTs from Cook County. The State qualifies for an 8-year transition period under the UPL rules. A RAI including the funding questions was sent on 11/12/03. The State's response was received on 2/10/04. The State's response was incomplete. A conference call was held on 3/18/04. Additional information was submitted on 3/19/04. An approval package is being prepared.
IL-03-013	OP	Approved 12/23/03	Changes in outpatient rates for county-owned hospitals. Eliminates annual adjustment floor for Cooke County to enable the State to continue its transition.
IL-03-014	Clinic	Approved 12/23/03	Clarifies enhanced payment to provider based Maternal and Child Health Clinics.
IL-03-015	ICF/MR	Approved 4/5/04	Effective 7/1/03 this SPA provides a 3.57% or 4% rate increase to ICF/MRs. The State has yet to provide information regarding funding sources for LTC services. A RAI with the funding questions was sent on 11/12/03. The State's response was received on 2/10/04. The State's response was incomplete. A conference call was held on 3/18/04. Additional information was received on 3/19/04. An approval package is being prepared.

IL-04-001	IH	Approved 12/21/04	Effective 6/1/04, this amendment establishes new supplemental payments for inpatient hospital services. CMS believes that payments under this amendment are to be funded by a new impermissible provider tax. Conference calls were held with the State on 4/7/04 and 4/13/04. The State has agreed to provide additional documentation to support the tax. A disapproval package was sent to OGC on 4/6/04. The disapproval package was cleared by OGC on 4/27/04 and put into clearance on 4/28/04. State requested an RAI be issued. The RAI was sent on 5/3/04. The State responded to the RAI on 9/22/04. The disapproval package was resubmitted to OGC for clearance on 10/8/04. The disapproval package has been submitted for departmental clearance.
IL-04-002	OP	Deemed Approved 12/21/04	Three types of supplemental payments to OP hospitals.
IL-04-004	SBS	Approved 6/28/04	School Based Services State revised SPA 6/21/04
IL-04-005	IH	Approved 5/17/04	Effective 1/10/04, Safety Net Adjustment Payments to hospitals are being revised. An approval package is being prepared.
IL-04-008	SBS	Approved 9/23/04	Local education agency fee for service general administration costs - SPA is attempting to get provisions of 04-04 approved under this transmittal number. State wants MA to pay for indirect costs not recognized by the cognizant agency.
IL-04-012	Pers. Care	Approved 12/3/2004	Modifies the way certain personal care providers are reimbursed.
IN-03-005	CM	Approved 12/23/2003	Aged and disabled deinstituionalized from NFs
IN-03-006	Other	Approved 3/4/2004	Hospice payment
IN-03-007	OP	Approved 8/10/04	Provides for add-ons to the Medicaid rates for inpatient and outpatient hospital services as funded by the State's Health Care for the Indigent Program.
IN-03-007	IH	Approved 8/10/04	Supplemental UPL payments to private and NSGO hospitals for indigent care. RAI sent 11/14/03. Response recv'd 02/11/04. Funding ok. Approval package prepared. NIPT reviewing OP UPL.
IN-03-008	OP	Approved 8/10/04	Provides for supplemental payments up to the UPL to private hospitals.
IN-03-008	IH	Approved 8/10/04	Supplemental UPL payments to private hospitals. RAI sent 11/14/03. Response recv'd 02/03/04. Approval package prepared. NIPT reviewing OP UPL.
IN-03-009	IH/DSH	Approved 8/10/04	Pays 175% DSH to public hospitals. RAI sent 11/14/03. Response rcv'd 12/29/03. Approval package prepared.
IN-03-010	OP	Approved 8/10/04	Provides supplemental UPL payments to Municipal hospitals and allows the State to make such supplemental payments in amounts that are either greater or lesser than the facility specific UPL provided that the aggregate payment amount does not exceed the aggregate UPL amount for the provider class.
IN-03-010	IH	Approved 8/10/04	Allows municipal hospitals to enter into agreements to receive more or less than their hospital-specific UPL gap in supplemental payments. Funded by provider IGTs. RAI sent 11/14/03. Response rcv'd 01/16/04. Approval package prepared. NIPT reviewing OP UPL.

IN-03-012	IH	Approved 05/17/04	Payment methodology for multiviseral transplants. RAI sent 11/14/03. Response rcv'd 12/29/03. Under review. There are no problems with this Plan change but there are many funding issues associated with other SPAs and the state's UPL estimate is not reasonable. Disapproval package prepared, call w/SMDscheduled. Waiting for additional information from State. Disapproval package cleared OGC and OCD, forwarded to HHS. UPL issues resolved. Approval package in OCD.
IN-03-014	PHY	Approved 2/23/04	Supplemental payment for services provided by full time medical school faculty practice groups. Payment is based on the "market rate".
IN-03-015	OP	Approved 8/10/04	Provides supplemental UPL payments to safety-net and disproportionate share hospitals and amends the DSH payment methodology.
IN-03-015	IH/DSH	Approved 8/10/04	Limits DSH and supplemental UPL "safety net" payments to new DSH hospitals. IGT's required in order to receive payments. RAI sent 11/13/03. Response recv'd 02/03/04. Approval package prepared. NIPT reviewing OP UPL.
IN-03-020	OP	Approved 2/26/04	Adjusts payment rate for OP and ASC reimbursed under MEDC ASC groupings. Payment is the lower of charges or state fee schedule.
IN-03-022	CM	Approved 2/26/2004	Assertive Community Treatment
IN-03-023	CM	Approved 2/2/2004	Developmentally disabled beneficiaries.
IN-03-027	Other	Approved 1/28/2004	Establishment of Psychiatric residential treatment facilities (PRTF)
IN-03-028	Reahb	Approved 6/23/2004	Addition of Assertive Community Treatment (ACT)
IN-03-034	NF	Approved 9/3/04	Reduces per diem base rates to nursing facilities by increasing the minimum occupancy rate used to calculate historical per diem costs. Also extends sunset of removal of profit add-on, extends date of historical cost inflation reduction, reinstitutes annual rebasing. RAI with funding questions issued on 03/05/04. State answers to follow-up funding questions received 8/30/04. Responses to funding questions indicate potential recycling of supplemental payments to NSGO NFs. Because SPA is a rate cut, approved but with follow-up funding review by RO of NSGO supplemental payments.
IN-03-035	IH	Approved 8/17/04	Decreases reimbursement for inpatient hospital services. UPL calculation for State-owned hospitals ok. Approval package prepared.
KS-03-012	NF	Approved 7/29/04	Modifications to the calculation of the case mix index factor. Updates the plan to delineate current inflation factors and cost center limits. Supplemental payment provision in another section of the State plan. RAI including funding questions sent on 9/18/03. State's response received on October 30, 2003. The State recycles supplemental payments to non-state government NFs. A disapproval package was sent to OGC on 1/12/04. Disapproval cleared by OGC on 1/13/04. The State withdrew its RAI response on 1/16/04. Response resubmitted 6/25/04 with appropriate sun setting language. Approval package in OCD 7/26/04.
KS-03-014	NF	Approved 1/22/04	Reestablished medical education payments. RAI including the funding questions sent on 9/4/03. State's response received on October 28, 2003. The State recycles payments to a non-state government teaching hospital. A disapproval package was sent to

			OGC on 1/9/04. Disapproval cleared by OGC on 1/13/04. On 1/13/04, the State submitted clarification that the payments proposed under this spa would not be made to the hospital that recycles. Approval package being prepared on 1/16/04. Approval package in OCD 1/21/04.
KS-03-015	IH	Approved 6/28/04	Revises the outlier payment methodology to increase the reimbursable percentage. Reduces DRG base rates by 2.84%. RAI including the funding questions sent on 9/4/03. State's response received on October 28, 2003. The State recycles payments to a non-state government teaching hospital. A disapproval package was sent to OGC on 1/9/04. Disapproval cleared by OGC on 1/13/04. State withdrew its original RAI response on 1/16/04. CMS is working with the State to resolve funding issues related to the KU Medical Center. Funding issues resolved per meeting on 6/10/04. The State resubmitted its response on 6/17/04. Approval package prepared 6/24/04.
KS-03-016	IH	Approved 6/28/04	DSH payments for public hospitals up to 175% of the cost of the uninsured. RAI including the funding questions sent on 9/4/03. State's response received on October 28, 2003. The State recycles payments to a non-state government teaching hospital. A disapproval package was sent to OGC on 1/9/04. Disapproval cleared by OGC on 1/13/04. State withdrew its original RAI response on 1/16/04. CMS is working with the State to resolve funding issues related to the KU Medical Center. Funding issues resolved per meeting on 6/10/04. The State resubmitted its response on 6/17/04. Approval package prepared 6/24/04.
KS-03-024	NF	Approved 7/29/04	Updates the plan to include revised State Administrative Regulations the became effective in July and August, 2003. A RAI with funding questions was sent 12/16/03. Response received 12/23/03. This SPA is contingent on the State's and CMS' resolution of SPA 03-012 which is pending due to funding issues. Working with State to resolve. The State is likely to withdraw its response to the RAI. The State withdrew its RAI response on 3/10/04. Response resubmitted 6/24/04. Approval package in OCD 7/26/04.
KS-03-031	IH	Approved 6/28/04	Annual routine adjustment to DRG weights and rates effective October 1, 2003. RAI sent on 3/11/04. Response received on 4/30/04 and is under review. Approval package prepared 6/24/04.
KS-03-032	IH	Approved 6/28/04	Provides for the consideration of unreimbursed outpatient hospital costs in calculating DSH payments effective October 1, 2003. RAI sent 03/12/04. Response received on 4/30/04 and is under review. Approval package prepared 6/24/04.
KS-03-033	IH	Approved 6/28/04	Reestablishes DSH payments to out-of-State hospitals effective October 1, 2003. DSH payments to out-of-state hospitals were previously terminated as of July 1, 2002. RAI sent 03/12/04. Response received on 4/30/04 and is under review. Approval package prepared 6/24/04.
KS-04-004	NF	Approved 12/21/04	Effective 7/1/04, updates the NF payment methodology. Payments will be increased by $2 m in 04 and $6 m in 05. Approval package in OCD.
KY-03-006	HH	Approved 10/31/2003	DME prior approval process

KY-03-008	IH	Approved 10/12/04	Changes hospitals rates from a per diem to a DRG methodology. Also increases DSH payments to public hospitals to 175% of uncompensated costs. Not part of this SPA, but elsewhere in Attachment 4.19-A the state makes supplemental payments to public hospitals. On 8/4/03 a RAI including funding questions was sent. The State's response to the RAI was received on 10/31/03. The State's response not sufficient. A significant portion of supplemental payments to non-state government providers is returned to the State. Providers retain 3% of the total payment plus 50% of the Federal share. The remaining funds are returned to State. The state share of supplemental payments and DSH payments to certain state-owned hospitals are funded through IGTs from other state entities. The State has not provided clear information as to who IGTs the funds or the source of the funds. A follow up email requesting additional information was sent on 11/21/03. Responses to the supplemental requests were received on 1/9/04 and 1
KY-03-012B	NF	Approved 7/29/04	Revises NF rates effective 11/1/03. Ancillary services for price-based nursing facilities will no longer be cost settled. Respiratory therapy and supplies will become part of the routine services per diem rate. The State has a supplemental payment provision for non-state government NFs. The State was sent an e-mail on 1/15/04 requesting funding information. We received a response to the email on 2/11/04. The states answers were not sufficient. A RAI was sent on 2/12/04. The State's response to the RAI was received on 5/12/04. Based on the State's response, almost the entire supplemental payment amount is being recycled. By telephone on 5/25/04, the State Medicaid director was informed of sun setting options or disapproval. A meeting was held with CMS and state officials on 6/14/04. The State requested a sunset date of 6/30/06. In a conference call on 7/12/04, the State agreed to sunset the supplemental payment methodology on 6/30/05. The State submitted additional information along with sunset
KY-03-015	OP	Approved 6/3/04	Revises the outpatient hospital reimbursement methodology. Services, except for those provided in a critical access hospital, will be reimbursed in accordance with an established fee schedule or at cost. Critical access hospitals will continue to be reim
KY-03-022	IH	Approved 4/19/04	Establishes new supplemental payments not to exceed $7.5 million to Appalachian regional hospitals effective 7/1/03. A RAI with the funding questions was sent on 10/20/03. The State's response was received on 1/20/04. The State's response was not sufficient. Follow up questions were sent to the State on 1/28/04. Conference calls were held with the State on 3/3/04 and 3/12/04. The State promised to submit additional information by 3/26/04. Additional information was received on 4/9/04. An approval package is being prepared.
LA-03-001	NF	Approved 6/28/04	Changes NFs to prospective facility specific per diems from statewide per diems. Not part of this SPA, but elsewhere in Attachment 4.19-D the state has supplemental payment provision to non-state government NFs. On 8/4/03 a supplement to the original RAI including funding questions was sent. The State's response to the RAI was received on 11/18/03. The RO issued a deferral of $1,235,925 on 11/10/03. The RO received a response to the deferral on 1/7/04 that is under review. A disapproval package cleared OGC on 1/16/04 and is in clearance. A conference call was

			held with the State on 1/20/04 in which the State was offered the opportunity to sunset their IGT program. The State withdrew their response to our RAI on 2/10/04. The state has indicated they will submit a sunset proposal in early June. The state submitted additional language on 6/22/04 to sunset the NF IGT program 6/30/05 and to formally restart the clock. To be approved.
LA-03-007	NF	Approved 10/09/03	Changes state NFs to a prospective rate equal to greater of Medicare PPS or costs. Changes may violate UPL provisions. Questions regarding recycling were not included in original RAI. On 8/4/03 a 2nd letter was sent to the state regarding UPL violations and recycling. The State responded on 9/15/03. The state corrected the UPL violations, but maintains recycling of funds elsewhere in the long-term care section of the plan. A disapproval package was sent to OGC for clearance. OGC expressed concerns with disapproval on 9/30/03. Approved on 10/09/03.
LA-03-013	ICF/MR	Approved 10/20/03	Increases per diem rates to state ICF/MRs up to the UPL. Questions regarding recycling of funds included in RAI. On 8/4/03 a supplement to the original RAI including the funding questions was sent. The State responded to the RAI on 9/18/03.
LA-03-018	OP	Approved 1/13/04	Reduces reimbursement rate for outpatient services provided in out of state hospitals.
LA-03-019	IH	Approved 1/4/04	Reduces rates to out-of-state hospitals. Not part of this SPA, but elsewhere in Attachment 4.19-A, the state makes supplemental payments to non-state public hospitals. On 8/4/03 a RAI including the funding questions was sent. The State's response to the RAI was received on 11/3/03. The State's response indicates that recycling of funds occurs with in-state non-state public hospitals, but funding for out-of state hospital payments is not recycled. An approval package is being prepared.
LA-03-023	Rehab	Approved 2/2/2004	IDEA IFSP 0-3 year olds
LA-03-026	IH	Approved 4/29/04	Revises DSH payments effective 7/1/03. Allows up to 175% of uncompensated costs to public hospitals. A RAI with funding questions was sent 11/5/03. We received the State's response on 2/5/04. The State intends to recycle $275 million or 31% of total DSH payments through IGTs back to the State. The State was informed by email on 2/18/04 that unless they demonstrated that providers retained 100% of the payments, the SPA would be disapproved. A disapproval package was sent to OGC on 3/31/04. An approval package is being prepared.
LA-03-027	OP	Approved 5/17/04	Payment up to the UPL for state government owned or operated hospitals.
LA-03-027	IH	Approved 5/17/04	Proposes to make inpatient and outpatient supplemental payments to State hospitals subject to UPL effective 7/3/03. We believe the state intends to recycle a portion of the payments. A RAI including the funding questions was sent to the State on 12/12/03. The States response was received on 3/31/04. An approval package is being prepared.
LA-03-	CM	Approved 8/31/2004	Early intervention svcs. For infants and toddlers w/disabilities under EPSDT (and Title V and IDEA).

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LA-03-031	CM	Approved 8/31/04	TCM for 1st time pregnant women.
LA-03-036	IH	Approved 5/17/04	Effective 9/21/03 this SPA revises DSH payments to small rural hospitals. Adds three new qualifying criteria and one new payment methodology. A RAI with the funding questions was sent 11/5/03. The State's response was received on 2/5/04. The State was informed on 3/12/04 that this SPA could not be approved until a sunset agreement was reached for their inappropriate recycling on UPL payments to non-state public hospitals. A disapproval package was sent to OGC on 4/1/04. The disapproval package was cleared by OGC on 4/26/04 and submitted for signature on 4/27/04. The State has withdrew their response to the RAI in order to work out a sunset agreement to end all inappropriate funding programs. The State resubmitted their response. The State has submitted sunset language in TN 03-37. An approval package is being prepared.
LA-03-037	IH	Approved 5/17/04	Effective 9/21/03, this SPA revises qualifications to receive non-state government owned or operated supplemental UPL payments. The State is also changing their UPL methodology from Medicare cost reimbursement principles to Medicare PPS principles. We believe the state intends to recycle a portion of the payments. A RAI with the funding questions was sent on 11/12/03. The State submitted language to sunset their IGT program on 6/30/05. An approval package is being prepared.
LA-03-038	IH	Approved 2/17/04	Reduces the reimbursement effective 10/1/03 for inpatient services to private acute hospitals and long-term care hospitals. Questions were informally sent to the State on 1/23/04. The State responded on 2/12/04. An approval package is being prepared.
LA-03-039	ICF/MR	Approved 2/17/04	Reduces reimbursement to private ICF/MRs effective 10/1/03. An approval package is being prepared.
LA-03-040	NF	Approved 8/3/04	Reduces the per diem case mix rate to private nursing facilities effective 10/1/03. Informal questions were sent to the State on 1/23/04. A formal RAI was sent on 2/12/04. The state requested the clock be restarted on 8/2/04. An approval package is being prepared.
LA-03-041	Rehab	Approved 2/5/2004	Payment reduction
LA-03-044	PHY	Approved 2/5/04	Clarification of language for physician reimbursement for pediatric surgery and orthopedic services.
LA-03-046	IH	Approved 4/29/04	Effective 10/21/03 rates to state-owned psychiatric hospitals would be increased. Informal questions were sent to the State on 1/23/04. A formal RAI was sent on 2/12/04. The State's response was received on 3/31/04. The State's response is under review. An approval package is being prepared.
LA-04-002	NF	Approved 8/24/04	This amendment revises NF rates effective 1/1/04. A RAI was sent on 4/6/04 due to previous pending SPAs and comprehensive language issues. The State requested the clock be restarted on 8/2/04. The State's response is being reviewed. An approval package is being prepared.
LA-04-	Other	Approved 5/27/04	Changes to reimbursement rate for kids from birth to 15 years.

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LA-04-007	HH	Approved 6/22/2004	Changes to homebound provision for infants and toddlers.
LA-04-008	Rehab	Approved 6/10/2004	Mental health services
LA-04-009	IH	Approved 6/21/04	Effective 4/1/04, rates for inpatient psychiatric services are being increased. An approval package is being prepared.
LA-04-010	Pers. Care	Approved 7/1/2004	Changes to payment methodology.
LA-04-013	IH	Approved 7/20/04	Effective 7/1/04 this amendment sets the statewide per diem rate for inpatient psychiatric services to the weighted average costs using 2002 cost reports trended forward by the PPS market basket index. An approval package is being prepared.
LA-04-014	ICF/MR	Approved 8/3/04	Effective 7/1/04 rates to private ICF/MRs are increased. The plan is under review. An approval package is being prepared.
LA-04-019	CM	Approved 11/9/2004	Ending program for high risk pregnant women.
LA-04-020	NF	Approved 10/12/04	Effective July 1, 2004 this amendment reduces private NFs rates after the July 1, 2004 rebasing of rates. The plan is under review. An approval package is being prepared.
MA-02-022	OP	Approved 2/23/04	Changes reimbursement for acute outpatient hospitals by updating rates and conversion factors.
MA-03-007	IH	Approved 1/22/04	Eliminates outlier payments and all other payments for inpatient stays over 20 days except for children under 21 or patients in distinct-part hospital psychiatric units. RAI w/comprehensive funding questions issued on 8/5/03. Response received 11/03/03 under review. SPA only makes coverage changes, approval package is in OCD. Will pursue potential funding issues as we review other hospital payment SPAs.
MA-03-008	OP	Approved 2/23/04	Reflects a change in the reimbursement method for acute outpatient hospital services to eliminate outlier payments for outpatient services.
MA-03-011	HH	Approved 5/24/2004	Home health and nursing services
MA-03-012	CM	Approved 5/24/2004	Chronic stable elderly
MA-03-014	IH	Approved 6/02/04	Revises payment methodology for State-owned non-acute care hospitals by moving to a Statewide payment to charge rate. Also allows 175% DSH to State-owned non-acute hospitals. RAI w/funding questions sent on 12/8/03. Response rcv'd 03/05/04. Approved with RO funding review.
MA-03-016	NF	Approved	Update base year costs for NF rates and institutes 3 new supplemental payments. RAI sent 12/08/03. Response recv'd 02/26 under review. Working with state on supplemental payments to NSGO NFs. Haven't received assurances from state on return of

			payments. If state does not withdraw response we may approve and pursue through review of MA 03-026 which is directly related to supplemental payments.
MA-03-022	IH	Approved 8/17/04	Revises payment methodology for non-state-owned chronic and rehab hospitals. RAI issued 02/27/04. Approval package prepared.
MA-03-026	NF	Approved 8/20/04	Expands number of NSGO NF eligible to receive UPL supplemental payments from two to eight. IGTs required from local governments or local "public authorities." RAI issued 02/27/04. RAI response received 5/24/04. Responses not adequate. RO funding review being conducted to determine whether NFs are truly NSGO, whether transferring entities are truly government-owned, and whether NFs retain 100% of payments. Draft disapproval package sent to OGC 7/16/04. SMD advised on 7/27 that without funding assurances SPA will either be disapproved or approved with 6/30/05 sunset. On 8/6, State again advised of sunset option or the option to withdraw RAI response. Disapproval package to OCD 8/11. Disapproval package signed by Administrator. State agreed to sunset all supplemental payments to NSGOs.
MA-04-002	IH	Approved	Revises methodology for inpatient psychiatric hospitals. Payment methodology limited to private hospitals. RAI sent 6/24/04. Response received 8/26/04.
MA-04-011	NF	Approved	Updates base year for rate calculation from 2000 to 2002. Removes three add-on payments. Approved 12/29/04.
MA-04-012	FQHC/RHC	Approved 12/17/04	Rate updates for FQHCs/Community Health Centers.
MD-03-012	IH	Approved	Proposes to pay state operated nursing homes full cost reimbursement in accordance with Medicare costs reimbursement principles at 42 CFR Part 413. RAI will be issued because CMS does not know how the non-federal side of the match is funding by the State. RAI was sent on 8/8/03, included funding questions.
MD-04-010	NF	Approved	Payment reductions
MD-04-017	Rehab	Approved 3/15/2004	Medical day care services
MD-04-018	PHY	Approved 3/9/04	Reimburses trauma physicians who provide trauma care in trauma centers to patients on the State Trauma Registry the Baltimore City Medicare rate.
MD-04-019	Rehab	Approved 8/31/2004	Therapy services for children in certain out of home placements.
MD-04-021	IH	Approved	Payment limits based on average length of stay.
MD-04-022	PHY	Approved 5/24/04	Allows physicians who are employed by the State to be paid at the Baltimore City Medicare rate.
MD-04-024	Rehab	Approved 6/25/2004	Mental health services

MD-04-025	Reha b	Approved 12/3/2004	Sets limits on coverage of rehab services.
MD-04-026	NF	Approved	Payment reductions
MD-04-029	IH	Approved	Modifies out of State payments to DC hospitals Slight reduction in spending $790,000. Approval being recommended.
ME-03-004	IH	Approved 7/06/04	Implements 175% DSH provision and updates base year used to determine the rate. A request for additional information, including the funding questions, was sent on 12/24/03. Response to RAI received on 4/7/04. State addressed our concerns on 6/10 call. Approved on 7/6/04.
ME-03-005	OP	Approved 4/22/04	Amends outpatient hospital reimbursement.
ME-04-006	IH	Approved 12/28/04	Effective 3/1/04 and 4/1/04. Increases reimbursement by adjusting rates to acute care hospitals, CAHs, and private IMDs. We are currently reviewing the State's response to determine if a hold harmless exists and State needs to address plan's comprehensive issues. Disapproval package is in OGC. As of 12/21/04, the State has not provided adequate documentation regarding the 5.1% increase.
ME-04-007	OP	Approved 12/1/04	Amends outpatient hospital reimbursement.
ME-04-011	Reha b	Approved 12/17/04	Imposes limits on adult day health services.
ME-04-012	IH	Approved 12/28/04	Effective 7/1/04. Terminates an add-on payment to private facilities and implements a ceiling of 117.5% on the PIP.
ME-04-013	OP	Approved 12/28/04	Amends hospital outpatient reimbursement.
MI-03-008	SBS	Approved 9/10/03	IDEA Assessment, School Based Services
MI-03-012	NF	Approved 6/14/04	Continuation of quality assurance assessment program payments for SFY 2004. Funded by a provider tax which the MI legislature continued for another SFY. Possible funding issues. Working with the State towards approval. State answered the funding questions on 12/15/03. RAI, including clarification request for the funding questions, issued to the State on 2/5/04. Response received on 3/19/04. Supplemental UPL payments in excess of allowable transitions amounts are returned to the State. A disapproval package is in clearance. Conference call was held with State on 5/26/04 and 6/2/04 in which sunsetting options were discussed. State indicated they will make necessary change to the SPA the week of June 7. Conference call held with State on 6/9/04. This amendment was modified to de-link proposed payments from providers that recycle payments. Further discussions to be held with State to sunset the recycling issue. Approval package prepared 6/10/04.

MI-03-014	IH	Approved 9/14/04	Updates DRG rates and clarifies the GME payment methodology. A RAI including the funding questions was sent on 12/22/03. Response received on 3/19/04. DSH payments to public facilities are returned to the State. Conference call was held with the State on 5/26/04 and 6/2/04 in which sun setting options were discussed. A disapproval package is in clearance. The State submitted acceptable sunset language on 8/27/04 for IH. They are also working with the legislature to sunset NF recycling as well. Forward to OCD for approval.
MI-04-001	PHY	Approved 8/31/04	Establishes payment rates for individual practitioner services. Rates are established as a fee screen for each procedure. Payment adjustments will be made for practitioner services provided by public entities. The adjustment will be equal to the 100% of the paid Medicare rate.
MI-04-008	Pers. Care	Approved 10/15/2004	Changes to services and rates.
MI-04-012	NF	Approved 10/19/04	Effective 10/1/04 sunsets UPL payments to non-state owned government facilities as of 10/1/05.
MN-03-010	Reha b	Approved 12/19/2003	Behavioral health
MN-03-013	Reha b	Approved 9/10/2003	Audiology services
MN-03-014	CM	Approved 2/9/2004	Mental health
MN-03-016	NF	Approved 3/11/04	Makes several revisions to the payment methodology for ICFs/MR that are not State Owned. Response received 12/23/03. Approval package is in clearance.
MN-03-017	CM	Approved 2/9/2004	Relocation coordination
MN-03-026	Reha b	Approved 12/19/2003	Behavioral health
MN-03-031	IH	Approved 4/23/04	NF reimbursement to clarify various sections and amend how the State reimburses for newly admitted residents in Tribally-owned or operated facilities. RAI sent to the State on 12/29/2003. Responses received on 1/26/2004. Approval package moved forward.
MN-03-038	SBS	Approved 3/26/04	Adds indirect cost component to approved rates.
MN-03-039	IH	Approved 6/30/04	Proposes to move approximately 40% of the annual Medicaid payment formerly made to hospitals to physician clinics for medical education and research. Disapproval package being prepared based on IP and OP issues related to donations and net expenditure issues. Call with the State on 5/7/04 to discuss options for this SPA. Call scheduled for 5/14/04 for further discussions with OCD. State provided alternative funding arrangement, however, NIRT believes it to be problematic. Disapproval moving to OGC on 6/4/04.
MN-04-	Othe r	Approved 12/20/04	Methods and Standards for Determining Payment Rates for Inpatient Hospital Services provided by non-state owned facilities (4.19A and

002			4.19B).
MN-04-002	IH	Approved 12/20/04	2% rate increase for IH services. Approval being prepared.
MN-04-004	Rehab	Approved 5/27/2004	Payment for mental health services
MN-04-005	HH	Approved 6/28/2004	Rates for supplies, equipment and appliances for use in the home.
MN-04-008	Rehab	Approved 9/3/2004	Changes to payment rates for mental health services.
MN-04-010	Rehab	Approved 9/7/2004	Changes to services and rates.
MN-04-011	OLP	Approved 9/28/04	Phlebotomy and case management services as component of clozaril patient monitoring system.
MN-04-012	OLP	Approved 9/10/04	CRNA Services provided in critical access hospitals will be reimbursed on a cost-based payment system.
MO-03-005	IH	Approved 10/9/03	Exempts Specialty Pediatric Hospitals from receiving DSH payments other than the Federal minimum payment. Supplemental payment provision in another section of the State plan. Standard funding questions issued on 8/12/03. A disapproval package was cleared by GC. State responded to funding questions on 10/2/03 and 10/8/03. Review of State's funding sources is continuing through terms of the Medicaid Partnership Plan entered into between the State and CMS.
MO-03-010	PHY	Approved 2/6/04	Payment for physician, dental and podiatry services provided by physicians, dentists or podiatrists not employed by the State of Missouri who are actively engaged in the training of physicians when the training takes place in a safety net hospital. Payment will be the lesser of the provider's actual charge for the services or the Medicare allowable reimbursement for the service.
MO-03-011	NF	Approved 6/4/04	Provides for an operations rate adjustment, a high-volume rate adjustment, and a high-volume grant for SFY 04. RAI, including funding questions, sent on November 6, 2003. State's response received on 12/16/03 and is under review. The State is recycling NF UPL payments. A disapproval package is being prepared. Disapproval package sent to OGC on 2/24/04. Disapproval package forwarded to OA.
MO-03-012	PHY	Approved 6/4/04	Provides for additional payment to Medicaid enrolled physicians, not employed by the State, providing Medicaid services in a safety net hospital.
MO-03-020	OP	Approved 7/28/04	Establishes coverage and reimbursement policy for inpatient and outpatient hospital services provided by out-of-state hospitals.
MO-03-020	IH-OH	Approved 7/29/04	Reimbursement for services provided to Missouri Medicaid beneficiaries in out-of-state hospitals. RAI issued on 3/11/04. Response received on 5/18/04 and is under review. Approval package in OCD 7/26/04.
MO-03-022	IH	Approved 7/8/04	Allows DSH payments up to 175% Increases DSH payments to State hospitals to 175% of uncompensated costs for SFY 2004 & 2005. RAI issued on 3/11/04. Response received on 4/16/04 and is

			under review. Approval package prepared 6/22/04.
MO-04-002	NF	Approved 12/21/04	Effective 4/16/04, modifies the high volume rate adjustment for nursing facilities in receivership. The plan is under review. Request for additional information, including the funding questions, was sent to the State on 6/28/04. Approval package sent to OCD.
MO-04-005	TRAN	Approved 12/16/04	Changes non-emergency transportation from an administrative to a medical service.
MO-04-006	OP	Approved 9/10/04	Revises section regarding who qualifies as a nominal charge provider, adds language on how the prospective OP payment percentage will be determined for hospitals missing a prior year cost report and adds definition of nominal charge provider.
MS-03-007	HH	Approved 3/4/2004	Provider cost reporting
MS-03-008	LTC	Approved 2/17/04	Effective 7/1/03 the audit schedule for all LTC facilities is being revised. Additional information regarding provider requirements to supply information has been added to the plan language. A RAI with the funding questions was sent on 10/17/03. The State's response was received on 1/21/04. An approval package is being prepared for clearance.
MS-03-009	NF	Approved 4/29/04	Revises interim payment rates for change of ownership effective 10/1/03. A RAI with the funding questions was sent to the State on 12/18/03. The State's response was received on 3/9/04. An approval package is being prepared.
MS-04-001	NF	Approved 5/17/04	This amendment revises NF rates effective 2/1/04. A new category of private NF rates for the severely disabled is being added. An approval package is being prepared.
MS-04-002	ICF/MR	Approved 5/17/04	Effective 1/1/04, this amendment would increase the reimbursement ceiling from 105% to 110% of median costs for private ICF/MRs. A RAI with the funding questions was sent on 3/2/04. The State's response to the RAI was received on 5/5/04. An approval package is being prepared.
MS-04-007	NF	Approved 10/12/04	Effective 8/1/04 revises the review of resident trust funds from annually to every two years. The plan is under review. An approval package is being prepared.
MT-03-005	CM	Approved 5/30/2004	non-foster care children who are abused and neglected
MT-03-022	IH/DSH	Approved 12/22/03	Revises DSH methodology to fully utilize allotment and implements hospital reimbursement adjustor to increase reimbursement to hospitals. Results in FFP increase of $17million in FFY '04 and $20 million in FFY '05. Funding questions sent on 9/12/03. Concern that HRA2 payment was hold harmless. State submitted revised methodology on 12/18/03 (HRA2 payments). The revised HRA2 methodology cleared any indication of a hold harmless.
MT-03-023	NF	Approved 5/19/04	Implements legislative funding increases for NF services in SFY 2004 and eliminates obsolete plan language. RAI was sent on 12/18/03 included funding questions. The State's response was received on 2/20/04. CMS requested a description of the flow of funds between NFs and the county governments. Had a call w/ MT during the week of 5/3, and provided the State w/ options. Disapproval package is in OCD. The State cannot guarantee that

			local-level payments are retained by the provider. CMS informed MT that SPA will be approved if 6/30/05 sunset date is added to plan pages. CMS is waiting for revised plan pages. Approved 5/19/04.
MT-03-029	OP	Approved 12/22/03	Outpatient Reimbursement
MT-04-002	IH	Approved 3/17/04	Revises reimbursement for hospital based psychiatric services for individuals under age 21. Expecting revised plan pages during the week of 2/16/04. Received revised pages on 2/20/04, however, methodology is improper. Informed State on 2/23/04 to revise methodology. Provided the State on 3/1/04 with recommendations to correct the language regarding the continuation of care payment. The State's revised language was not comprehensive and brought up more questions. RAI issued on 3/16/04 including the funding questions. Approved on 3/17/04.
NC-03-003	Rehab	Approved 8/19/2004	Mental health services.
NC-03-009	NF	Approved	Develops a prospective case mix. Is funded with a variable tax. Plan Changes are approvable --tax is being modified to comply with the law.
NC-03-011	Other	Approved 2/6/04	Adjusts payment rates for prosthetic and orthotic devices.
NC-03-012	Other	Approved 2/6/04	Adjusts payment rates for extended services to pregnant women childbirth and parenting.
NC-03-014	Other	Approved 3/8/2004	Private duty nursing
NC-03-015	HH	Approved 2/20/2004	DME prior approval process
NC-03-016	Other	Approved 3/8/04	Adjusts payments for physician fees and personal care services.
NC-03-017	Other	Approved 3/8/04	Adjusts payments for orthotics and prosthetics.
NC-03-018	NF	Approved 3/08/04	Freeze on inflation --savings of 9 Million FFP in 2004 and 13 million in 2005 approval package prepared
NC-03-022	Other	Approved 2/20/2004	Private duty nursing
NC-04-008	Pers. Care	Approved 9/23/2004	Change in eligibility criteria for pers. care services.
ND-03-019	NF	Approved 1/12/04	Remove recapture of depreciation provision from the plan. Funding questions and specific SPA questions sent on 10/6/03. Received response on 10/27/03.
ND-	PHY	Approved	Physician service limit - removes 12 visit per year limitation.

04-004		2/2/04	
ND-04-007	IH/DSH	Approved 6/21/04	Effective 4/1/04, increases DSH payments to hospitals with high Medicaid utilization. Will recommend for approval on 6/21/04.
NE-03-005	NF	Approved 12/15/03	Updates the language for long term clients with special needs. Has a $0 Federal budget impact. Funding questions and specific SPA questions sent on 9/5/03 - State responded on 9/12/03. Known funding issues will be addressed in SPA (03-009).
NE-03-006	OP	Approved 12/1/03	Changes to cost-based reimbursement methodology. Reduces the percentage of the cost to charge ratio used to determine costs.
NE-03-006	NF	Approved 12/1/03	Implements a series of cost-cutting measures. Results in a federal reduction of $2,547,432 for FFY 2004. Funding questions and specific SPA questions sent on 9/5/03 - State responded on October 7, 2003. Approved on 12/1/03.
NE-03-009	NF	Approved 9/14/04	Reduces the number of components in the rate, postpones the rebasing of the rate for fiscal years 2004 and 2005, reduces rates to facilities with 1,000 or fewer inpatient Medicaid days, and establishes a $20 ceiling on the fixed cost component of the rate. Funding questions and specific SPA questions sent on 9/5/03 - State responded on October 8, 2003. State recycles supplemental payments below 100% of UPL and disapproval package was forwarded to OS. On 8/9/04, received revised pages with sunset provision. Plan will be recommended for approval during week of 9/6/04.
NE-04-002	Other	Approved 5/3/2004	Hospice services
NE-04-003	Pers. Care	Approved 9/23/2004	Proposes to add personal care services outside the home.
NE-04-004	NF/ ICF/ MR	Approved 12/28/04	Effective 7/1/04 this amendment increases reimbursement to ICF/MRs for fy '04. The amendment is funded by an ICF/MR tax and appears to meet the statutory requirements at 1903(w). The payout methodology proposed under the SPA may violate a hold harmless provision. Disapproval package is in OGC. Will try to get State to withdraw their response to the RAI.
NE-04-005	IH	Approved 11/30/04	Effective 9/1/04 this amendment adds a DSH pool to reimburse private, non-profit hospitals in the Omaho metropolitan area up to the facility-specific limits.
NH-03-002	NF	Approved 2/09/04	Changes UPL calculation method from cost to RUGs - would result in a potential increase in supplemental payments - Response to RAI incomplete, follow-up letter sent to state on 7/25/03. More comprehensive funding inquires sent on 8/4/03. State provided an inadequate response - Disapproval package was prepared - State withdrew its response on 9/16/03. The State submitted a new set of responses on 11/10/03. The response did not completely address recycling issues. New disapproval package has cleared OGC and is in PCPG. Have reached an agreement. This amendment will be approvable once the State has submitted revisions to this SPA and NH 03-004. State sent withdraw letter on 02/05/04. State submitted new response and revised plan pages on 02/06/04. Approval package in OCD.

NH-03-003	NF	Approved 02/17/04	Changes inflation factor for nursing facility payments, also eliminates specific base year language. RAI, which did not included funding questions, sent 6/12/03, no response. Follow-up letter with comprehensive funding questions sent on 8/4/03. State responded to funding questions on 9/9/03, and 10/27/03 we evaluated the response and have problems w/recycling of supplemental payments to NFs. Disapproval package is in OCD. Scully met with Gov. on 12/8/03 and State agreed to withdraw it's 9/9/03 response. Have reached an agreement. This amendment will be approvable once the State has submitted revisions to NH 03-002 and NH 03-004. Approval package in OCD (02/09/04).
NH-03-004	DSH	Approved 2/20/04	Allows 175% DSH for State psychiatric facilities - RAI, including specific funding questions sent on 7/25/03. Follow-up letter with more comprehensive funding inquires sent on 8/4/03. State responded to funding questions on 9/9/03 and 11/10(25)/03. The last response provided assurances that real State dollars were used to match DSH payments and no payments were returned. Approval and Disapproval packages are in OCD. Scully met with Gov. on 12/8/03 and State agreed to withdraw it's 9/9/03 response. Have reached an agreement. This SPA should be approvable pending receipt of plan page changes. Working with State on revised plan pages. Approval package in OCD.
NH-03-007	NF	Approved 02/17/04	Changes to NF per diem rate. RAI sent 12/8/03. Response received 01/23/04. Plan will be approvable upon receipt of plan page changes for NH 03-002 and NH 03-004. Approval package in OCD (02/09/04).
NH-03-008	IH	Approved 03/16/04	Suspends Capital Pass-through payment -- Projected Savings 1.2 million FFP. Nursing home funding issues resolved during review of NH 03-002. Hospital funding issues resolved during review of NH 03-004. Working with State to resolve effective date issues. Approval package forwarded to OCD.
NH-04-004	Rehab	Approved 6/25/2004	Adds mental health services.
NJ-03-008	IH/DSH	Approved 8/24/04	175% DSH for University of Medicine and Dentistry, New Jersey. RAI sent 12/8/03. Response recv'd 12/26/03. State has not provided comprehensive answers to funding questions. State provided updated response to funding questions on 02/20 claiming providers keep all money. Following up with additional clarifying questions in phone call to State. Additional assurances provided verbally, but State was unwilling to provide written assurance prior to the 90th day. Revised response received 6/1/04. Disapproval package sent to OGC 8/12/04. Conference call with SMD on 8/12/04 -- SMD provided assurances that providers keep payments. State confirmed funding assurances in writing -- 8/19/04. Approval package prepared.
NJ-03-009	IH/DSH	Approved 8/24/04	175% DSH for Piscataway. RAI sent 12/8/03. Response recv'd 12/26/03. State has not provided comprehensive answers to funding questions. State provided updated response to funding questions on 02/20 claiming providers keep all money. Following up with additional clarifying questions in phone call to State. Additional assurances provided verbally, but State was unwilling to provide written assurance prior to the 90th day. Revised response received 6/1/04. Disapproval package sent to OGC 8/12/04. Conference call with SMD on 8/12/04 -- SMD provided assurances that providers

			keep payments. State confirmed funding assurances in writing -- 8/19/04. Approval package prepared.
NJ-04-003	Rehab	Approved 5/24/2004	Expansion of program
NJ-04-004	IH	Approved 12/21/2004	Changes the timing of reimbursement for hospital capital facility projects so that reimbursement begins upon project completion and facility operation. RAI sent on 9/15/2004.
NJ-04-013	FQHC/RHC	Approved 11/19/04	Reporting requirements for FQHCs.
NM-04-006	Other	Approved 9/23/04	Payment rates for other types of care.
NV-03-003	PHY	Approved 2/2/04	Changes the methodology for calculating CPT code reimbursement for a variety of providers. By using the Lewin Group's study of Medicaid rates, the State adjusted rates either up or down to help conform to national norms.
NV-03-005	IH	Approved 3/8/04	Revises the DSH distribution Methodology. RAI sent on 2/8/2003. Response received on 12/10/03. State responded that no providers are required to return funds. However, CMS has information that details the DSH IGT program in the State that requires that providers only keep a portion of the funds. NIRT is working with the State to reach mutual understanding of what is actually happening. Approval possible.
NV-03-007	Clinic	Approved 7/1/04	Reimbursement of ambulatory surgical centers (hospital based and free standing) at 150% of UPL.
NV-03-009	NF	Approved	Implements final phase of NF reimbursement methodology. State's response received on 3/31/04. State has decided that waiver is necessary for provider taxes. The waiver request forwarded to CMS on 5/6/04. State and NIRT discussing effective date of the waiver request. NIRT is reviewing the State's proposal to resolve the effective date issue. If resolution is not reached by COB 6/28/04, the State will withdraw the amendment.
NV-03-010	IH	Approved 3/11/04	Revises State GME payment pool. Responses under review. State's response received on 12/23/03. Approval package in clearance.
NV-03-011	Other	Approved 12/22/03	Reserved beds-theraputic leave
NV-04-001	NF	Approved 6/28/04	Proposes to reclassify ICF's/MR for rate calculation. Response received on 5/5/04. Approval package being prepared.
NV-04-005	PHY	Approved 9/23/04	Enhanced reimbursement for pediatric providers for specified CPT codes.
NV-04-009	PHY	Approved 8/25/04	Reimbursement for professional services related to organ transplants.
NV-	Othe	Approved	Clarification of reimbursement methodology for emergency and non-

04-013	r	11/15/04	emergency transportation services, hospice services and hospice long term care.
NY-02-048	NF	Approved 2/20/04	Changes the allowable reimbursement of a nursing home tax from 6% to 5%. State withdrew responses to RAIs. State responded to RAI in letter dated November 26,2003. Approval package is in clearance. Awaiting public notice for change to move forward.
NY-03-004	NF	Approved 1/22/04	Institutes a rate reduction for rural hospitals to encourage improved productivity and efficiency. Funding questions sent September 11, 2003. Responses received on 12/17/2003. Approved.
NY-03-006	IH	Approved 01/28/04	Makes various changes and rate adjustments to public hospitals regarding outlier payments, efficiency, equipment..... The adjustments result in an overall cut to providers. RAI sent on 9/23/2003. Responses received on 12/16/2003. Language problems in SPA related to subject to the availability of funds language. We has contacted the State requesting a language change and believe we will be able to approve the SPA once State agrees to the language change.
NY-03-007(A)	IH/DSH	Approved	Allows 175% DSH for State facilities. . Effective April 1, 2003 - March 31, 2005.
NY-03-007(B)	IH/DSH	Approved	Allows 175% DSH for non-state government owned or operated facilities. Effective April 1, 2003 - September 30, 2003.
NY-03-022	NF	Approved 2/20/04	Continues to limit reimbursable administrative and general costs for nursing facilities. Continues to reduce rates of payment for services to encourage improved productivity and efficiency. Extends the requirement of a three percent increase, state wide in the percentage of nursing home Medicare days. Continues the elimination of the trend factor for the base year. Approval Package is in clearance.
NY-03-027	OP	Approved 2/26/04	Adjusts rates of payments for OP clinics, emergency departments and freestanding diagnostic/treatment services. Continues certain provisions that were to sunset on 3/31/03 and 9/30/03.
NY-03-028	OP	Approved 3/3/04	Adjusts rates of payment for freestanding clinic services.
NY-03-029	Clinic	Approved 2/26/04	Freezes the rates of payment for ambulatory surgical services provided at freestanding and hospital based surgery centers that were in effect on 3/31/03.
NY-03-032	Clinic	Approved 6/17/04	Diagnostic & Treatment center services reimbursement. State wants CMS to pay for the uninsured.
NY-03-033	HH	Approved 2/20/04	Payment rate adjustments
NY-03-034	Other	Approved 2/20/04	Adult day health services
NY-03-035	Reahb	Approved 12/22/03	OMRDD Day Treatment
NY-03-	NF	Approved 3/11/04	Updates base year in ICF/DD facilities payment methodology, and includes day services funding into the ICF/DD rate. Supplemental

036			funding questions issued 8/5/03. Responses received 12/16/04. Approval packaged moved to clearance.
NY-03-041	OP	Approved 7/12/04	Non-institutional payments, transitional supplemental payments for freestanding D&T centers as indigent care programs or 330 homeless centers to reflect costs associated with transition to managed care.
NY-03-042	IH/DSH	Approved 03/23/04	Revises definition of "Eligible Rural Hospital" for high need indigent care patients. Proposes a continuation of the current indigent care distribution. RAI sent on 9/23/03. Responses received on 12/23/2003. Approval Package is in clearance, NIRT meeting with State to discuss issues related to the 175% and the sunset requirement.
NY-03-044	NF	Approved 6/21/04	Develops a standardized process for assessing the feasibility of capital mortgage refinancing, including a standard formula for determining the net cost benefit of refinancing , inclusive of all transactions and closing costs. Analyst received response on 5/5/04. Approval package being prepared.
NY-03-045	Rehab	Approved 4/27/04	Mental health
NY-03-046	IH	Approved 02/18/04	Establishes pass through payments or other methodologies for payment for innovative medical devices. RAI sent on 10/1/2003. Responses received on 12/23/2003. Approved on 2/18/04.
NY-03-060	IH	Approved 8/5/04	This amendment authorizes additional DSH up to 175 percent of each non-State public hospital's medical assistance and uninsured patient losses. CMS believes that there are issues with recycling of DSH funds below 100% - despite sunset agreement. Per OCD, DS will speak with State about sunset understandings. Disapproval package moved to OCD.
NY-04-006	IH	Approved 10/19/04	Updates DRG system to incorporate changes made by Medicare. Approval expected. SPA will be presented at Thursday's NIRT Meeting.
NY-04-008	CM	Approved 10/8/04	CM for Target Group A.
NY-04-020	IH	Approved 1/12/05	SPA proposes to extend rate adjustments to general hospitals, other than public hospitals, to address workforce recruitment and retention issues. Responses received on 10/15/04.
NY-04-023	Clinic	Approved 9/23/04	Workforce recruitment and retention - Diagnostic and treatment center services.
NY-04-024	NF	Approved 09/28/04	6% tax reimbursement. Revises capital financing for RHC for AIDS facilities. Phase out of add-on. Eliminates hospital based add-on. Updates Regional Direct and Indirect Adjustment Factors.
OH 04-004	NF	Approved 7/20/2004	Modifies peer groups as a result OMB circular. No budget impact
OH-03-008B	IH	Approved 10/21/03	Continues the State's authority to make DSH payments to general hospitals and psychiatric hospitals. State counts individuals age 22-64 in the qualification process. Ohio also makes supplemental payments under other sections of the plan. Plan was split into a part A, which contains just the general hospital DSH payments and Part B, which contain the IMD DSH payments. State also informed CMS that bank loans are used to finance supplemental payments. CMS approved the general hospital DSH payment and is reviewing the

			funding and IMD DSH issues now in 03-08-B.
OH-03-010	NF	Approved	Exempts Childrens hospitals from a rate freeze. Effective date issue, which the state is fixing. State to confirmed funding answers provided in 03-08 are still accurate.
OH-030-11	IH	Approved 11/17/04	SFY 2003 cost reports
OH-03-012	IH	Approved 5/20/2004	Supplemental Payments to County Hospitals --modifies formula to comply with region financial management review recommendation. State survey is expected to be completed 4/28/04 on how counties fund the State match. State has confirmed that no payments are returned to it.
OH-03-017	NF	Approved	Annual submission of cost reports and editorial changes. To be approved
OH-03-018	NF	Approved	Imposes rate limitations --savings $80 million ffp. To be approved
OH-03-024	Rehab	Approved 11/4/2004	Reh. Prov. By Hab Providers.
OH-04-001	NF	Approved 4/29/2004	This amendment makes house cleaning changes
OH-04-002	ICF/MR	Approved 7/20/2004	Switched from a fixed base-year to a rolling base year. State projects savings
OH-04-003	IH?DSH	Approved 7/20/2004	Modifies DSH payments to general and psychiatric hospitals.
OH-04-009	NF	Approved	Modifies traumatic brain injury section of the payment methodology
OK-03-008	PHY	Approved 12/30/03	Payment of publicly employed physicians and osteopaths at a percentage of Medicare.
OK-03-017	IH	Approved 5/17/04	Provides rate increases effective 1/1/04 to hospitals being paid facility specific per diems. All hospitals will have their rate increased to statewide or peer group medians. In addition rates will be increased 2% for inflation. The state has at least one problematic funding source. The State makes supplemental payments to non-state government hospitals which return approximately 40% of the payment to the State. The plan is under review. A conference call was held with the State on 1/20/04 to request additional information regarding the funding arrangement for non-state public hospitals. The State has asked for a 7/1/05 sunset to end their IGT program. CMS has offered a 1/1/05 sunset. We are waiting for the State to respond. A request for additional information was sent on 3/11/04. The State's response was received on 3/19/04. Additional information was received from the State on 5/10/04 in which the State agreed to sunset their IGT program on 6/30/05. An approval

			package is being prepared.
OK-03-019	IH	Approved 1/22/04	Provides for inflation update to payment rates for most NFs. A RAI including the funding questions was sent to the State on 12/9/03. A response to the RAI was received on 12/30/03. The State response indicates there are not funding problems. An approval package is being prepared for clearance.
OK-03-021	Other	Approved 2/20/2004	PRTF payment
OK-03-022	IH	Approved 5/17/04	Provides for 2% rate increase to critical access hospitals. The State has a recycle program in which 40% of supplemental payments to non-state public hospitals are returned to the State. The State has asked for a 7/1/05 sunset to end their IGT program. CMS has offered a 1/1/05 sunset. We are waiting for the State to respond. A request for additional information was sent on 3/11/04. The State's response was received on 3/19/04. Additional information was received from the State on 5/10/04 in which they agreed to sunset their IGT program on 6/30/05. An approval package is being prepared.
OK-03-024	PHY	Approved 2/2/04	Increases allowable outpatient physician visits.
OK-03-025	IH	Approved 1/22/04	Effective 1/1/04 NF rates are increased for annual inflation adjustment. The State has addressed the funding questions and there does not appear to be any inappropriate funding. An approval package is being prepared for clearance.
OK-03-027	Reheb	Approved 11/15/2004	Adds Assertive Community Treatment and revises codes to reflect HCPCs codes.
OK-04-003	OLP	Approved 10/12/04	Proposes to pay physician assistants at the same rate as physicians.
OK-04-005	IH	Approved 10/12/04	Effective 7/1/04, the per diem to Level 1 trauma centers will be increased by $206 per day. An approval package is being prepared.
OR-03-010	CM	Approved 2/26/2004	Mental health
OR-03-017	IH	Approved 2/23/04	Reinstates outlier reimbursement to all hospitals for all age clients. RAI issued on 11/5/2003. Responses received on 11/25/03. In a follow-up call, the State said that there was no recycling of payments under this section of the plan and provided confirmation e-mail of CMS understanding. The State has submitted adequate assurance that the State does not recycle. An approval package is in clearance. More information was requested at the clearance meeting. CMS auditors are reviewing IH funding.
OR-03-	NF	Approved 05/26/04	Revises the State's methodology for calculating NF Medicaid payment rates. This SPA has tax implications. RAI sent

018			1/2/04.Response received on 4/6/04. Approval forwarded for comment.
OR-03-020	IH	Approved 8/17/04	SPA proposes to make IH tax reimbursable cost, makes changes to the State's outlier payment reimbursement, DRG system, and GME reimbursement. Responses received on May 19, 2004 - under review. Approval pending State submittal of information required for tax waiver approval.
OR-04-007	IH	Approved 11/30/04	175% DSH SPA. Approval package being prepared.
OR-04-011	Reha b	Approved 9/23/2004	Revise payment methodology for psychiatric day treatment centers.
OR-04-012	IH	Approved	Freeze the unit value used n the DSH calculation for the DRG reimbursed hospitals.
PA-03-008	NF	Approved 01/04/05	Held sun-set call with the Sate on Friday April 23, 2004 and several follow-up calls. State does not wish to have the State plan disapproved and will withdraw to avoid disapproval. However, the State has requested that we approve this plan and handle the sun-set discussions/agreement in Pa 03-12. That plan amendment makes payments funded by a new tax, which is under CMS review. Since funding is such a central element to Pa 03-12, the State like to have all funding issues consolidated in one State plan amendment. The provision in 03-08 have been approved by CMS multiple times in the past and provide modest relief to facilities 50 cents to $5 a day to high volume Medicaid facilities.
PA-03-011	IH	Approved 5/26/04	Initially, amendment eliminated direct medical education, community access and certain DSH payments. The legislature has restored funding for these programs. State share for these payment is from State appropriations. State does not use IGTs or CPEs.
PA-03-012	NF	Approved 01/04/05	Nursing facility single value supplemental payment. This plan redistributes taxes revenues collected through a new provider tax.
PA-04-009	IH/DSH	Approved	Plan establishes an additional class of DSH providers that will be eligible to receive 12.5 million in DSH payments. Rec: Approval clearance meeting in Dec
PA-04-012	NF/OH	Approved	Limits on Certain NF payments and outpatient hospital payments
PA-04-013	IH/DSH	Approved	Creates new class of DSH providers
RI-03-005	NF ICF/MR	Approved 11/3/03	Completely revises payment methodology for nursing facilities and ICFs/MR. RAI w/funding questions sent on 10/2/03. State responded on 10/16/03. Responses look good, the State does not make supplemental payments and does not have a county system of government or any public NF providers. UPL methodology issues have been resolved. Approval package has been prepared.
RI-03-006	IH	Approved 1/08/04	Revises DSH payment methodology by adjusting payment pools. RAI w/funding questions sent on 10/2/03.Response received 10/10/03. Generally the responses look okay, however, we are looking into a potential hold harmless situation with the hospital tax and the DSH payment to private hospitals. OGC has given OCD a preliminary opinion on the tax. Approved w/changes to plan

			language.
RI-04-004	IH/DSH	Approved 04/29/04	Reinstates Pool "I" DSH payments to facilities providing mental health services. State provided updated answers to funding questions. Approval package in OCD.
RI-04-005	NF	Approved	Updates reimbursement methodology for nursing facilities.
RI-04-007	NF	Approved 9/14/04	Updates reimbursement methodology for nursing facilities.
SC-03-007	OP	Approved 1/5/04	DSH Qualification Criteria Revisions - Incorporating Medicaid utilization trend into prospective Medicaid inpatient and outpatient cost settlements for public hospitals under 100% of the Medicaid UPL.
SC-03-007	IH	Approved 1/6/2003	Continues DSH and provides for retrospective cost reimbursement. If interim rates are below Medicaid costs, then the State will make a supplemental payment. SPA is approvable.... CMS is tweaking approval letter as the State has some pending deferrals.
SC-03-014	NF	Approved 5/26/04	Amendment implements Sun-Set Provision
SC-03-015	OP	Approved 6/17/04	Incorporates changes made to the inpatient and outpatient hospital rate setting methodology and the South Carolina Medicaid DSH Program effective on or after October 1, 2003.
SC-03-015	IH	Approved 6/16/2004	175 DSH Amendment
SC-04-006	OP	Approved 10/12/04	Incorporates a change made to the Medicaid inpatient and outpatient hospital rate setting methodology effective on or after July 1, 2004 that will allow for retrospective inpatient and outpatient cost settlements for qualifying hospitals with burn intensive care units.
SC-04-006	IH	Approved 10/12/04	Retrospective cost reimbursement for hospitals that operate a burn unit.
SC-04-007	NF	Approved 10/19/2004	annual NF rate updates
SD-03-001	IH	Approved 10/20/03	Reduces payment to out-of-state facilities to make the payment structure more similar to the in-state hospitals. Funding Question sent 8/7/08. Response received on 8/29/03.
SD-03-003	NF	Approved 10/5/04	Increases the capital cost limitation from $10.32 per resident day, to $10.55 per resident day. Allows for a 2.2% inflationary increase for SFY '04. Received sunset language on 8/31/04. SPA will be recommended for approval in week of 10/4/04.
SD-04-001	NF	Approved 12/21/04	Effective 7/1/04, this SPA increases the ceiling for the capital cost component and omits language regarding the 2.2% increase in '04. State submitted requested info. Amendment will be recommended for approval during week of 12/20/04
SD-04-003	IH	Approved 09/21/04	Effective 4/1/04 this amendment is budget neutral and revises the qualifying DSH amounts to SD hospitals.
TN-03-003	SBS	Approved 2/3/04	School Based Services - EPSDT

TN-03-004	NF	Approved 1/4/05	Revises enhanced payments to behavioral units effective 7/1/03. This SPA extends the first year payment rate to facilities that did not participate in the program until the 2nd year. A RAI with the funding questions was sent on 11/5/03. The State's response was received on 10/13/04 and is under review. An approval package is being prepared.
TX-03-013	IH	Approved 2/17/04	Revises the NF base rate and enhanced direct care add-on effective 9/1/03. A RAI with the funding questions was sent on 11/5/03 along with questions regarding the comprehensiveness of the proposed. The State's response was received on 1/30/04. An approval package is being prepared for clearance.
TX-03-015	IH	Approved 4/5/04	Changes reimbursement for inpatient hospital services effective 9/1/03. This SPA eliminates the recalculation of the standard dollar amounts for SFY 2004 and 2005. This amendment allows certain over 100 bed hospitals to receive cost reimbursement. A RAI with the funding questions was sent on 10/17/03. The State's response was received on 1/15/04. The State's response was not sufficient. The State uses IGTs from local and state owned providers to the fund the State share of supplemental and DSH payments. Additional questions were sent to the State on 1/28/04. A conference call was held with the State on 2/13/04. Additional information was provided by the State on 3/2/04 and is under review. Additional changes were requested from the State on 3/11/04. A conference call was held with the State on 3/16/04. The State agreed to submit additional changes. Additional information was received on 3/19/04. An approval package is being prepared.
TX-03-018	IH	Approved 4/5/04	Changes the DSH payment methodology effective 9/1/03. This SPA eliminates the "proxy method" of establishing uninsured costs in the hospital-specific DSH limits. This SPA is in response to a recent OIG audit. A RAI with the funding questions was sent on 10/17/03. The State's response was received on 4/14/04. The State's response was not sufficient. The State uses IGTs from local and State owned providers to fund the State share of supplemental and DSH payments. Additional questions were sent to the State on 1/28/04. A conference call was held with the State on 2/13/04. Additional information was provided by the State on 3/2/04 and is under review. Additional changes were requested from the State on 3/11/02. A conference call was held with the State on 3/16/04. The State has agreed to submit additional changes. Additional information was received on 3/19/04. An approval package is being prepared.
TX-03-020	Other	Approved 11/4/04	Changes to lab, physician & ambulance reimbursement.
TX-03-022	NF	Approved 5/17/04	Effective 10/1/03 provides for new supplemental payments to non-state public NFs. A RAI with the funding questions was sent 12/4/03. The State's response to the RAI was received on 3/3/04. The State's response was insufficient. A conference call was held with the State on 3/29/04 in which additional information was requested from the State. Additional information was received on 4/30/04. An approval package is being prepared.

TX-03-024	IH	Approved 7/6/04	Removes dollar cap on supplemental payments to rural non-state government hospitals effective 10/11/03. The State has not sufficiently responded to funding questions regarding their inpatient program. The State uses IGTs from local government providers to fund these payments. Informal questions were sent to the State on 1/28/04. A conference call was held with the State on 2/13/04. A RAI including funding questions was sent on 3/2/04. The State's response was received on 5/28/04. The State's response was insufficient. An email requesting additional information was sent on 6/2/04. Additional information was received 6/9/04 and is under review. An approval package is being prepared.
TX-03-030	OP	Approved 6/28/04	Provides for a supplemental payment for state owned or operated hospitals for outpatient services. The supplemental payment will not exceed the difference between the total annual Medicaid payments and federal UPL.
TX-03-030	IH/OH	Approved 06/28/04	Effective 12/23/03 this plan would establish new supplemental payments to state hospitals up to the UPL. A RAI with funding questions was sent on 3/2/04. The State's response was received on 5/28/04. The State's response was insufficient. An email requesting additional information was sent on 6/2/04. Additional information was received on 6/16/04 and is under review. An approval package is being prepared.
TX-03-032	Reha b	Approved, 2/5/2004	Day activities and health services.
TX-04-002	OP	Approved 7/9/04	Increase AIR to 2003 rate for dental and optical at tribal 638 facility. Increase number of times/year may be claimed.
TX-04-003	IH	Approved 4/29/04	Effective 2/7/04, this amendment adds Midland county to the list of non-state public hospitals receiving supplemental payments. An approval package is being prepared.
TX-04-007	Reha b	Approved 11/4/2004	Changes to MR services.
TX-04-008	CM	Approved 11/4/2004	Chgs to CM services.
TX-04-013	NF	Approved 8/17/04	Effective 7/1/04 rates for the enhanced direct care staffing program for NFs are being modified. The plan is under review. An approval package is being prepared.
TX-04-014	IH	Approved 7/20/04	Effective 5/29/04 amends supplemental payments to urban non-state government hospitals to include two additional hospitals. An approval package is being prepared.
TX-04-017	IH	Approved 10/5/04	This amendment revises the definition for largest MSAs for DSH purposes. The amendment allows for DSH payments up to 175% of uncompensated costs for certain hospitals. An approval package is being prepared.
TX-04-018	IH	Approved 11/30/04	Effective 9/1/04 this amendment reestablishes GME payments. This amendment also revises the methodology for high-volume adjustment payments. The plan is under review.
TX-04-019	Pers. Care	Approved 10/8/2004	Pers. Care services payment under consumer direction.
TX-04-	IH	Approved 11/2/04	Effective 9/1/04 this amendment makes various technical changes to the inpatient methodology. This plan is under review. Informal

022			questions were sent to the State on 10/12/04. We are waiting for the State to respond.
TX-04-024	NF	Approved 10/12/04	Effective 9/1/04 this amendment eliminates the supplemental payment to non-state government nursing facilities. An approval package is being prepared.
TX-04-026	NF	Approved 12/8/04	Effective 10/2/04 the state is revising the redistribution of funds recouped from the direct care enhancement program. The plan is under review.
TX-04-026	NF	Approved 12/8/04	Effective 10/2/04 the state is revising the redistribution of funds recouped from the direct care enhancement program. The plan is under review.
UT-03-010	IH	Approved 2/02/04	Revises the outlier payment methodology. Supplemental payment provision in another section of the State plan. Supplemental funding questions issued 8/11/03. The State submitted a response on 11/6/03. Clarifications regarding the State's response were requested on 11/6/03. Working with the State to approve. Call with the State scheduled for 1/20/04. Awaiting imminent submittal of revised plan language and funding clarifications 1/21/04. Approval package being prepared 1/29/04.
UT-03-010	IH	Approved 2/02/04	Revises the outlier payment methodology. Supplemental payment provision in another section of the State plan. Supplemental funding questions issued 8/11/03. The State submitted a response on 11/6/03. Clarifications regarding the State's response were requested on 11/6/03. Working with the State to approve. Call with the State scheduled for 1/20/04. Awaiting imminent submittal of revised plan language and funding clarifications 1/21/04. Approval package being prepared 1/29/04.
UT-03-011	IH/OH	Approved 1/12/04	Introduces a severity-based payment system utilizing the Resource Utilization Group System (RUGS). Supplemental funding questions issued 8/11/03. The State responded to the RAI on October 14, 2003.
UT-03-011	IH/OH	Approved 1/12/04	Introduces a severity-based payment system utilizing the Resource Utilization Group System (RUGS). Supplemental funding questions issued 8/11/03. The State responded to the RAI on October 14, 2003.
UT-03-014	IH	Approved 08/31/04	Redistributes DSH payments to rural government owned hospitals. Has a $0 Federal Budget impact. Supplemental funding questions issued 9/17/03. Plan language still needs adjustment. Guidance given to the State on 3/29/04. Proposed language not comprehensive. State withdrew response to RAI on 5/4/04 to resolve issues regarding the effective date and language issues. Both issues resolved and will be recommended for approval at 8/31 clearance meeting.
UT-03-014	IH	Approved 08/31/04	Redistributes DSH payments to rural government owned hospitals. Has a $0 Federal Budget impact. Supplemental funding questions issued 9/17/03. Plan language still needs adjustment. Guidance given to the State on 3/29/04. Proposed language not comprehensive. State withdrew response to RAI on 5/4/04 to resolve issues regarding the effective date and language issues. Both issues resolved and will be recommended for approval at 8/31 clearance meeting.
UT-03-015	Rehab	Approved 3/26/2004	Mental Health
UT-	Reha	Approved	Mental health

03-019	b	3/26/2004	
UT-03-020	Rehab	Approved 3/26/2004	Substance abuse
UT-03-021	Rehab	Approved 3/26/2004	Mental health
UT-03-024	CM	Approved 9/1/2004	Establishes payment methodology for CM provided to chronically ill persons.
UT-04-004	CM	Approved 11/10/2004	Case management under EPSDT.
UT-04-005	NF	Approved 11/10/2004	Effective 7/1/04 increases the base rate for NFs and modifies add-on payments for an average increase of $4.05 for affected NFs. RAI sent on 9/15/04. Approval package in OCD.
UT-04-005	NF	Approved 11/10/2004	Effective 7/1/04 increases the base rate for NFs and modifies add-on payments for an average increase of $4.05 for affected NFs. RAI sent on 9/15/04. Approval package in OCD.
UT-04-011	HH	Approved 11/10/2004	Changes to payment rates.
UT-04-012	IH	Approved 11/10/2004	DSH payments for government-owned rural hospitals. RAI sent on 9/1/04. State submitted response on 9/29/04.
UT-04-012	IH	Approved 11/10/2004	DSH payments for government-owned rural hospitals. RAI sent on 9/1/04. State submitted response on 9/29/04.
VA-03-001	HH	Approved 11/10/2004	Increase service limits and recipient copays, modify prior authoriztion process for psychiatric services
VA-03-002	IH/NF	Approved 11/10/2004	Modifies inflation increases for inpatient hospital and nursing facility services. The inflation modifications are not problematic, however, the increase applies to services regardless of what provider is providing them. Therefore, CMS could argue that there is a link between this amendment and the approved supplemental payment provisions elsewhere in the approved plan that are not being modified by this amendment. Disapproval will not remove or prevent Virginia from making the supplemental payments, although it will deny inflation increases to all providers.
VA-03-002	IH/NF	Approved 11/10/2004	Modifies inflation increases for inpatient hospital and nursing facility services. The inflation modifications are not problematic, however, the increase applies to services regardless of what provider is providing them. Therefore, CMS could argue that there is a link between this amendment and the approved supplemental payment provisions elsewhere in the approved plan that are not being modified by this amendment. Disapproval will not remove or prevent Virginia from making the supplemental payments, although it will deny inflation increases to all providers.
VA-03-003	OP	Approved 11/10/2004	Limits private OP hospital payments to 80% of allowable costs. Establishes prospective reimbursement for rehab agencies.
VA-03-	Rehab	Approved 11/10/2004	Behavioral health

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VA-03-006	NF	Approved 11/10/2004 .	Addresses/eliminates a potential duplication of payments situation in the rate structure by clarifying a rate structure for specialized services. Private facilities may only provide these services.
VA-03-006	NF	Approved 11/10/2004 .	Addresses/eliminates a potential duplication of payments situation in the rate structure by clarifying a rate structure for specialized services. Private facilities may only provide these services.
VA-03-008	IH	Approved 11/10/2004 .	This plan modifies the how the State plans state teaching hospitals. It lowers the basis rate and increases the indirect medical education and DSH payments by the same amount of the decrease.
VA-03-008	IH	Approved 11/10/2004 .	This plan modifies the how the State plans state teaching hospitals. It lowers the basis rate and increases the indirect medical education and DSH payments by the same amount of the decrease.
VA-03-011	CM	Approved 11/10/2004 .	Increases copays, requires prior authorization, increases home health limits, freezes CPE, covers stretcher vans.
VA-04-003	IH	Approved 11/10/2004 .	Distributes a rate cut to providers
VA-04-003	IH	Approved 11/10/2004 .	Distributes a rate cut to providers
VA-04-004	Reha b	Approved 11/10/2004 .	Community mental health services
VT-02-022	ICF/ MR	Approved 11/10/2004 .	Increases reimbursement to furloughed inmates admitted to an ICF/MR from 110% to 150% of the Standard Medicaid rate. Also, decreases the minimum occupancy rate for direct care staff nurses. State responded to funding questions on 8/14/03.
VT-02-022	ICF/ MR	Approved 11/10/2004 .	Increases reimbursement to furloughed inmates admitted to an ICF/MR from 110% to 150% of the Standard Medicaid rate. Also, decreases the minimum occupancy rate for direct care staff nurses. State responded to funding questions on 8/14/03.
VT-03-009	IH	Approved 11/10/2004 .	Establishes an add-on payment to the base rate for instate hospitals, adds a CAH peer group, adjusts the rate to out-of-state facilities and increases the base payment by 5% to non-teaching hospitals with over 80 beds. Supplemental funding questions issued 10/14/03. Response to RAI received on 10/28/03. The State withdrew its response to the RAI on 1/23/04, and responded on 5/28. Received revised plan pages which removed the 21-65 waivered population from the plan language. Will recommend SPA for approval during week of 8/16.
VT-03-009	IH	Approved 11/10/2004 .	Establishes an add-on payment to the base rate for instate hospitals, adds a CAH peer group, adjusts the rate to out-of-state facilities and increases the base payment by 5% to non-teaching hospitals with over 80 beds. Supplemental funding questions issued 10/14/03. Response to RAI received on 10/28/03. The State withdrew its response to the RAI on 1/23/04, and responded on 5/28. Received revised plan pages which removed the 21-65 waivered population from the plan language. Will recommend SPA for approval during week of 8/16.
VT-03-013	IH	Approved 11/10/2004 .	Creates a border teaching hospital class and provides a rate increase for this class. Response to RAI received on 4/7/04. Plan will be recommended for approval once State submit revised plan pages. Approved on 5/26/04.

VT-03-013	IH	Approved 11/10/2004.	Creates a border teaching hospital class and provides a rate increase for this class. Response to RAI received on 4/7/04. Plan will be recommended for approval once State submit revised plan pages. Approved on 5/26/04.
VT-04-004	NF	Approved 11/10/2004.	Effective 5/1/04, this amendment establishes a state wide prospective method for determining and reimbursing the costs of ancillary services and items. Also accounts for different categories of costs now permitted by changes in Federal regulation. This plan is under review and will be recommended for approval during the week of 9/6/04.
VT-04-004	NF	Approved 11/10/2004.	Effective 5/1/04, this amendment establishes a state wide prospective method for determining and reimbursing the costs of ancillary services and items. Also accounts for different categories of costs now permitted by changes in Federal regulation. This plan is under review and will be recommended for approval during the week of 9/6/04.
VT-04-005	NF	Approved 11/10/2004.	Effective 7/1/04 this amendment increases the cost category caps for private nursing facilities. Will be recommended for approval during the week of 11/22.
VT-04-005	NF	Approved 11/10/2004.	Effective 7/1/04 this amendment increases the cost category caps for private nursing facilities. Will be recommended for approval during the week of 11/22.
VT-04-006	IH	Approved 11/10/2004.	Effective 7/1/04 this amendment increases updates the base rate by an inflationary factor of 1.4%.
VT-04-006	IH	Approved 11/10/2004.	Effective 7/1/04 this amendment increases updates the base rate by an inflationary factor of 1.4%.
WA-03-005	Rehab	Approved 11/10/2004.	Mental health
WA-03-019	Other	Approved 11/10/2004.	Updating services for Categorically Needy and Medically Needy Programs.
WA-03-020	NF	Approved 11/10/2004.	Revises methodology for NF payments to reimburse tax. RAI Response received on 3/9/04. Tax waiver still under review. Call with the State on 5/14/04 and one scheduled for 5/20/04 regarding possible sunset provision. Disapproval package in OGC. Response withdrawn on 6/2/04.
WA-03-021	OP	Approved 11/10/2004.	Methods and standards for establishing payment rates for outpatient hospital , physician and trauma center services.
WA-03-022	CM	Approved 11/10/2004.	Case management for infant medical care
WA-04-008	CM	Approved 11/10/2004.	High risk infants.
WA-04-015	NF	Approved 11/10/2004.	Nursing Facility Rates
WA-04-015	NF	Approved 11/10/2004.	Nursing Facility Rates

WI 03-005	Reha b	Approved 11/10/2004.	Mental health services.
WI 03-006	SBS	Approved 11/10/2004.	School Based Services Rate Methodology. Supplemental payments for SBS and cost-based reimbursement to replace fee schedule.
WI-04-009	ESR D	Approved 11/10/2004.	ESRD rates for free standing providers which match Medicare rates.
WV-03-001	NF	Approved 11/10/2004.	This amendment provides supplemental payments to State NFs
WV-03-001	NF	Approved 11/10/2004.	This amendment provides supplemental payments to State NFs
WV-03-002	OP	Approved 11/10/2004.	Amends the payment methodology for state owned and non state government-owned hospitals by providing for payments within the UPL.
WV-03-002	NF	Approved 11/10/2004.	This amendment provides supplemental payments to State hospitals
WV-03-002	NF	Approved 11/10/2004.	This amendment provides supplemental payments to State hospitals
WV-03-003	PHY	Approved 11/10/2004.	Amends payment methodology for state-owned and non-state government-owned physicians and dentists by providing for payments within the UPL.
WV-03-008	Othe r	Approved 11/10/2004.	Nurse Practitioners - coverage and payment considerations
WV-04-003	NF	Approved 11/10/2004.	technical non-FFP impact type changes.
WV-04-003	NF	Approved 11/10/2004.	technical non-FFP impact type changes.
WY-03-002	IH	Approved 11/10/2004.	Establishes a supplemental payment to non-state public hospitals for inpatient and outpatient services effective 7/1/03. The proposed plan language includes IGT requirements. A RAI including the funding questions was sent on 11/21/03. The State's response was received on 2/19/04. The State's response indicates inappropriate funding, non-comprehensive language, and UPL problems. A conference call was held with the State on 3/23/04 and the State agreed to submit additional information. Additional information was received on 4/15/04 and is under review. An approval package is being prepared.
WY-03-002	IH	Approved 11/10/2004.	Establishes a supplemental payment to non-state public hospitals for inpatient and outpatient services effective 7/1/03. The proposed plan language includes IGT requirements. A RAI including the funding questions was sent on 11/21/03. The State's response was received on 2/19/04. The State's response indicates inappropriate funding, non-comprehensive language, and UPL problems. A conference call was held with the State on 3/23/04 and the State agreed to submit additional information. Additional information was received on 4/15/04 and is under review. An approval package is

			being prepared.
WY-03-003	OP	Approved 11/10/2004.	Qualified rate adjustment payments for outpatient hospital services.
WY-03-04	Rehab	Approved 11/10/2004.	Occupational therapy
WY-04-001	IH	Approved 11/10/2004.	Effective 1/1/04, language regarding OBRA 93 limits for DSH is being added. The plan is under review. A conference call was held with the State on 2/25/04. The State has promised to submit revisions. The revisions were received on 3/31/04. An approval package is being prepared.
WY-04-001	IH	Approved 11/10/2004.	Effective 1/1/04, language regarding OBRA 93 limits for DSH is being added. The plan is under review. A conference call was held with the State on 2/25/04. The State has promised to submit revisions. The revisions were received on 3/31/04. An approval package is being prepared.
Disapproved SPAs			
AR-02-017	PHY	Disapproved 03/07/03	Provides supplemental payment to physicians affiliated with state operated medical school. Payments based on the difference between current Medicaid reimbursement and the federal Medicaid maximum. State has filed appeal w/DAB. State submitted new SPA AR-03-12 for cost-based reimbursement.
AR-03-005	Rehab	Disapproved2/17/2004	UPL adjustment for private rehabilitation services for individuals with mental illnesses (RSPMI).
CA-03-028B	CM	Disapproved7/6/2004	Targeted case management - continuation of existing part of state plan, which presents problems as it covers costs of public guardian and probation agencies.
CO-03-024	NF	Disapproved 4/02/04	Adjusts NF rate to include cost of provider tax as an allowable cost. Individual provider rate adjustments will vary based on Medicaid utilization. A request for additional information, including the funding questions, was sent on 12/10/03. Response received on 1/5/04. Tax issues. Possible withdrawal of response. State was willing to cooperate but has now requested a disapproval. Disapproval package is in the Department as of 4/1/04.
IA-04-002	Rehab	Disapproved 12/23/2004	Adds case planning functions.
IL-04-010	SBS	Disapproved 9/28/04	Local education agency payment for round trip SBS transportation.
IN-02-021	Rehab	Disapproved10/8/2004	Mental health services provided by CWS institutions; Problems with use of restraints on children and lengthy periods of seclusion; the providers appear to be IMDs; costs appear to represent housekeeping functions labelled as rehab.
MN-03-006	NF	Disapproved 6/1/04	Provides increase to the Disproportionate Share Nursing Facilities pool for supplemental payments. State cannot make assurance on providers keeping payments. State withdrew its response to the RAI on 11/21/03. State resubmitted responses for decision on this SPA. Disapproval package prepared and forwarded to OCD. State requested that disapproval be moved forward 5/26/04. SPA

			disapproved on 6/1/04. NIRT expects State to request reconsideration hearing.
MT-04-004	CM	Disapproved3/25/2004	Special education
OK-02-014	PHY	Disapproved 5/28/03	Pays state employed doctors and dentists usual and customary charges. State later submitted SPA 03-08, which was approved based on market rates.
OK-03-026	OP	Disapproved 9/3/04	Access to Essential Care (ATEC) supplemental outpatient payment adjustment for hospitals located in a hospital district pursuant to the Oklahoma Trust & Authority Act.
OK-03-026	IH	Disapproved 9/3/04	Effective 1/4/04 provides for supplemental payments to hospitals for inpatient and outpatient hospital services located in newly created hospital districts. The State already makes supplemental payments to non-state government owned hospitals. This appears to be an attempt to funnel IGTs from private hospitals through a "public" hospital district. A conference call was held with the State on 1/20/04 to discuss the funding arrangements for this amendment. The State was informally sent questions regarding this SPA on 1/21/04. A RAI was sent to the State on 3/2/04. We received the State's response to the RAI on 6/8/04. The State's response is under review. A conference call was held with the State on 7/19/04. The State is to provide additional information. A disapproval package was sent to OGC for clearance on 8/5/04.
RI-02-009	CM	Disapproved8/14/2003	Foster care and child welfare services
VA-02-009	PHY	Disapproved 6/16/03	Supplemental payments to a new class of physicians who are affiliated with state academic medical centers.
Withdrawn SPAs			
AL-03-003	CM	SPA Withdrawn 2/4/2004	CM service SPA no longer needed as state ended related 1915(b) waiver. CM supported waiver.
AR-03-012	PHY	SPA Withdrawn 6/7/04	Reimbursement of providers affiliated with state operated university.
AR-04-018	IH	SPA Withdrawn 12/1/04	Revises supplemental payments to non-state government hospitals. We expect this amendment to be withdrawn. We expect to work out a sunset agreement as part of 04-013 that will make this SPA unnecessary.
AR-04-019	IH	SPA Withdrawn 12/1/04	Revises supplemental payments to non-state government hospitals. We expect this amendment to be withdrawn. We expect to work out a sunset agreement as part of 04-013 that will make this SPA unnecessary.
CO-03-015	CM	SPA Withdrawn 9/3/2003	Payment rates
FL-03-019	ICF/MR	SPA Withdrawn 12/12/03	Changes Payments to private ICF/MRs effective 7/1/03. The incentive component of the per diem rate will not longer receive inflation adjustments. A RAI including the funding questions was sent on 10/17/03. The State requested the SPA be withdrawn on 12/12/03.

FL-03-024	CM	SPA Withdrawn 5/21/2004	School based services
FL-04-005	OP	SPA Withdrawn 3/8/04	Amends payment methodology for outpatient hospital services.
FL-04-008	SBS	SPA Withdrawn 5/25/04	Provides orientation and mobility services that are related to the IEP or FSP with the intent to provide assistance to blind and visually impaired individuals to achieve maximum independence.
GA-03-002	CM	SPA Withdrawn 11/23/2003	Foster Care Children at Risk
IN-03-028	CM	SPA Withdrawn 2/2/0/2004	Costs of Assertive Community Treatment
KS-02-021	NF	SPA Withdrawn	Supplemental UPL payments for participating public providers
KS-03-023	Rehab	SPA Withdrawn 1/17/2004	Long term head injuries
KY-04-001	PHY	SPA Withdrawn 7/8/04	Increases the relative value unit conversion factor for anesthesia services from $29.02 to $29.67, making it uniform with the conversion factor applied to other physician services; provides for anesthesia add-on payment for recipients of extreme age; amends reimbursement for a service which does not have a set rate. Call with
LA-03-031	CM	SPA Withdrawn 5/7/2004	Services for 1st time mothers.
MD-04-011	Rehab	SPA Withdrawn 12/23/2003	Therapuetic Foster Care
MD-04-012	PHY	SPA Withdrawn 2/11/04	Amendment to pay physicians employed by the State at the Baltimore City Medicare rate. Replace by 04-22.
MN-03-020	IH	SPA Withdrawn 02/02/04	Amends to include in the definition of the six teaching hospitals that receive medical education funding, "hospitals owned and operated by a nonprofit corporation that owns and operates any of the six teaching hospitals." RAI issued August 8, 2003. Responses received Nov. 5, 2003. Amendment withdrawn. CMS initiating audit action.
MN-03-028	IH	SPA Withdrawn 3/16/04	Proposes to increase payments to Fairview University Medical Center through IGTs. * Fairview is a privately owned facility. RAI issued 12/18/03.
MN-04-017	CM	SPA Withdrawn 9/29/2004	Child welfare services labelled as case management.
MN-04-021	IH	SPA Withdrawn	Methods and standards for determining payment rates for services provided by IH
MS-03-010	IH	SPA Withdrawn 12/30/03	Increases DSH payments to State hospitals to 175% of uncompensated costs for SFY 2003 & 2004 as provided for in BIPA. CMS believes that the State already requires an amount approximately equal to the Federal share of payments to be returned

			to the State. A RAI with the funding questions was sent on 10/17/03. The State requested the SPA to be withdrawn on 12/30/03.
NC-03-010	PHY	SPA Withdrawn 5/17/04	Supplemental payments up to cost for faculty practices in public medical schools.
NC-03-013	IH	SPA Withdrawn 4/1/2004	Freeze on inflation --savings of 13. Million FFP in 2004 and 25 million in 2005
NC-03-019	IH	SPA Withdrawn 4/1/2004	Technical change -- more current version of grouper software will be implemented
NC-04-001	IH	SPA Withdrawn	This plan was mistakenly submitted to split NC 04-02-- that plan provides for 175% DSH and makes modification to regular hospital payment methods. The State is supposed to withdraw this SPA.
NH-03-005	NF	SPA Withdrawn 7/30/2004	Institutes a new "Medicaid Quality Incentive" payment for nursing facilities, pays differential rates to government vs. private facilities. Payments are based on the number of Medicaid beds in the facilities. State share payments are raised with a proposed bed day tax on NFs. RAI, including funding questions sent on 8/14/03. State responded to funding questions on 10/1/03 and 10/27/03. We have problems w/recycling of supplemental payments to NFs. Disapproval package is in PCPG, GC signed off. Have reached an agreement - we will ask State to withdraw all responses and will work to restructure the tax associated with this SPA. Received draft withdrawal letter on 1/21/04. State sent the finalized RAI response withdrawal letter on 1/23/04. State sent letter withdrawing the SPA and a companion uniformity tax waiver request on 7/30/04. State enacted a broad-based, uniform tax that does not require a uniformity waiver.
OK-03-009	CM	SPA Withdrawn, 6/24/2004	To provide TCM for seriously emotionally disturbed children at risk for psychiatric hospitalization.
RI-04-003	IH	SPA Withdrawn	Reinstates Pool "I" DSH payments to facilities providing mental health services. There was an error in the submission and the State submitted a corrected version under a new transmittal number 04-004. SPA 04-004 was approved on 4/29/04.
TN-03-001	CM	SPA Withdrawn 2/10/2004	State funded foster care services
TN-04-001	Rehab	SPA Withdrawn 9/1/2004	Imposition of a $30, 000 lifetime limit.
TX-03-011	CM	SPA Withdrawn 3/29/2004	Merging of medical and social service case management.
TX-04-006	Rehab	SPA Withdrawn 7/2/2004	Removes service coordination for individuals enrolled in local authorities mental retardation programs.
UT-03-022	Rehab	SPA Withdrawn 8/9/2004	Revised service definitions to conform with HCPCS code requirements of HIPAA Transaction Rule.
UT-03-023	Rehab	SPA Withdrawn 8/9/2004	Revised service definitions to conform with HCPCS code requirements of HIPAA Transaction Rule.

UT-04-006	NF	SPA Withdrawn 6/2/04	Nursing Care Facility Assessment and changes to NF rates to recognize the Medicaid cost of the Assessment. The plan is under review. The State indicated they may withdraw this SPA in its entirety. SPA withdrawn in letter dated 6/2/04.
WA-03-017	Rehab	SPA Withdrawn 2/24/2004	Definition of Medical Necessity
WA-03-025	CM	SPA Withdrawn 1/22/2004	Substance abuse
WV-04-002	Rehab	SPA Withdrawn 5/21/2004	Behavioral health in juvenile justice facilities.

Attachment G

NATIONAL WAIVER DATA
by STATE
Timeframe 10/01/2003 - 09/30/2004 **1/12/2005**

State	TC 1115 Waiver COS Subtotal	FS 1115 Waiver COS Subtotal
Alabama	20,974,949	18,883,367
Alaska	0	0
Amer. Samoa	0	0
Arizona	3,537,016,678	2,529,572,331
Arkansas	88,322,781	55,280,305
California	605,185,189	415,941,655
Colorado	3,153,599	1,641,773
Connecticut	0	0
Delaware	324,908,216	170,143,867
Dist. Of Col.	51,314,015	35,014,399
Florida	84,213,639	51,520,341
Georgia	0	0
Guam	0	0
Hawaii	475,935,932	279,604,785
Idaho	0	0
Illinois	2,164,295,771	1,133,139,143
Indiana	0	0
Iowa	0	0
Kansas	0	0
Kentucky	(2,759,001,830)	(1,933,234,437)
Louisiana	0	0
Maine	123,340,461	84,057,175
Maryland	1,505,370,296	805,085,732
Massachusetts	4,499,281,016	2,339,576,976
Michigan	0	0
Minnesota	218,899,278	114,356,115
Mississippi	1,206,853	1,067,166
Missouri	40,673,006	25,361,099
Montana	0	0
N. Mariana Islands	0	0
Nebraska	0	0
Nevada	0	0
New Hampshire	0	0
New Jersey	15,344,079	8,016,174
New Mexico	2,585,513	2,248,513
New York	18,606,816,855	9,337,761,353
North Carolina	0	0
North Dakota	0	0
Ohio	0	0
Oklahoma	899,457,376	666,526,542
Oregon	1,516,801,631	974,928,210
Pennsylvania	0	0
Puerto Rico	0	0
Rhode Island	269,802,895	157,690,438
South Carolina	1,121,741,145	814,979,576
South Dakota	0	0
Tennessee	4,491,869,273	3,014,452,321
Texas	0	0
Utah	48,292,325	35,019,251
Vermont	308,226,156	198,797,640
Virgin Islands	0	0
Virginia	76,722	55,658
Washington	33,746,454	29,315,569
West Virginia	0	0
Wisconsin	218,382,450	154,512,501
Wyoming	0	0
TOTAL	**38,495,831,675**	**21,502,902,538**

This data includes current quarter expenditures as well as adjustments for prior period waiver expenditures.
The waiver data includes Lines 9 (collections) and 10.C. (overpayments) adjustments that are appropriatly reported on the CMS-64.9P as line 10.B. adjustments.
Depending upon the State reporting, DSH expenditures and Drug Rebate Offsets applicable to 1115 demonstrations may or may not be included in the above data.
The waiver data includes expenditures subject to the budget neutrality cap, but not eligible for FFP (i.e., LA County PHP revenues.)
The waiver data includes expenditures not subject to the budget neutrality cap, but which are required to be reported (i.e., TennCare Accruals).
The waiver data does not include SCHIP waiver expenditures.
The waiver data is only as good as the states report on the CMS-64 (i.e., FL does not correctly report their FP waiver expenditures.)
Kentucky data reflects reclassification as non-waivers, now treated as regular Medicaid expenditures

Attachment H

PERCENT MEDICAID PAYMENTS ASSOCIATED WITH DUALLY ELIGIBLE
BY STATE FOR 2002

STATE	% DUAL PAYMENTS	TOTAL DUAL PAYMENTS
AK	27.6%	$ 172,728,800
AL	48.1%	$ 1,180,126,745
AR	53.5%	$ 1,017,371,277
AZ	28.2%	$ 767,232,925
CA	40.0%	$ 8,798,906,577
CO	47.6%	$ 930,781,215
CT	62.9%	$ 1,990,425,739
DC	29.6%	$ 263,971,232
DE	39.2%	$ 242,335,405
FL	43.2%	$ 3,701,419,616
GA	37.0%	$ 1,531,510,173
HI	40.4%	$ 238,324,417
IA	51.5%	$ 900,185,962
ID	21.6%	$ 158,388,350
IL	40.1%	$ 2,990,720,310
IN	48.7%	$ 1,734,204,303
KS	53.8%	$ 747,154,237
KY	36.9%	$ 1,182,110,477
LA	38.8%	$ 1,154,160,333
MA	53.9%	$ 3,326,580,322
MD	37.4%	$ 1,300,636,554
ME	38.9%	$ 640,438,410
MI	43.0%	$ 1,800,730,253
MN	52.9%	$ 2,210,823,541
MO	46.5%	$ 1,836,674,941
MS	47.3%	$ 1,117,462,030
MT	43.8%	$ 208,730,461
NC	45.7%	$ 2,585,926,990
ND	64.8%	$ 259,840,321
NE	49.1%	$ 576,181,981
NH	55.3%	$ 399,407,586
NJ	52.8%	$ 2,757,642,850
NV	35.0%	$ 211,383,217
NY	49.9%	$ 14,637,754,054
OH	48.8%	$ 4,296,472,416
OK	48.6%	$ 948,089,726
OR	39.8%	$ 791,349,424
PA	46.8%	$ 3,862,915,026
RI	48.9%	$ 592,215,483
SC	39.1%	$ 1,024,203,996
SD	47.0%	$ 217,816,113
TN	40.5%	$ 1,353,128,469
TX	39.2%	$ 4,019,318,274
UT	30.0%	$ 256,458,960
VA	47.3%	$ 1,336,595,166
VT	41.0%	$ 240,731,229
WA	32.0%	$ 876,620,434
WI	56.5%	$ 1,973,751,035
WV	41.6%	$ 576,880,590
WY	47.2%	$ 121,989,751
TOTAL	45.0%	$ 86,060,807,696

DATA SOURCE: MEDICAID STATISTICAL INFORMATION SYSTEM
NOTE: NEW MEXICO MISSING

Attachment I

Medicaid Drug Spending and Phased-down State Contributions
FY 2006 President's Budget projections in billions

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Medicaid Prescription Drugs Expenditures											
Total computable:											
Gross	43.6	25.2	19.9	21.6	23.6	25.6	27.9	30.5	33.1	35.9	38.9
Rebates	9.7	5.6	4.5	4.9	5.3	5.8	6.3	6.9	7.5	8.1	8.8
Net	33.9	19.5	15.4	16.7	18.2	19.8	21.6	23.6	25.6	27.8	30.1
Federal Share:											
Gross	25.2	14.8	11.8	12.8	14.0	15.2	16.6	18.2	19.8	21.5	23.3
Rebates	5.6	3.3	2.7	2.9	3.2	3.4	3.8	4.1	4.5	4.8	5.3
Net	19.6	11.5	9.2	9.9	10.9	11.8	12.9	14.1	15.3	16.6	18.0
Prescription Drug Account Receipts from states for phased-down state contribution for dual eligibles	--	6.8	9.7	10.6	11.6	12.7	13.9	15.1	16.5	17.9	19.4

Office of the Actuary/CMS
1/12/2005

Medicare Advantage

There have been long documented problems with risk selection in the Medicare+Choice program. I have introduced legislation in the past to ensure that health plans to not engage in risk selection via imposition of higher cost sharing on services that chronically ill and disabled beneficiaries utilize such as chemotherapy and dialysis. What can be done to ensure that the past risk selection practices are not repeated in the new Medicare Advantage and drug plans?

Answer:

As mandated by the MMA and earlier statutory provisions, CMS will be reviewing plan benefit packages submitted by MA organizations to ensure that cost sharing structures do not enable risk selection by MA organizations. CMS has also published regulations that implement the new MA program announcing its intention to prevent discriminatory behavior by plans. For example, the final MA regulation states that CMS plans to review levels of cost sharing for access to dialysis and chemotherapy drugs and cost sharing for medical services provided during inpatient stays, outpatient facilities and ambulatory surgical centers to ensure that cost sharing levels are not prohibitive for beneficiaries, thereby discouraging enrollment from certain types of beneficiaries.

CMS will be putting out final formulary guidance as a part of implementing the new drug benefit. The draft guidelines clearly state that CMS will review all plan formularies to guard against discriminatory practices. CMS is firmly committed to ensuring that all beneficiaries have access to medically necessary drugs at the lowest possible cost. In addition, plans will be required to have adequate coverage determination and appeals processes in place to further assist beneficiaries in gaining access to the drug that they need.

Studies indicate that payments to Medicare HMOs are 7 to 15 percent higher, on average, compared to traditional Medicare. What is the rationale for the overpayments, including payments to health plans for graduate medical education and through disproportionate share hospital, or DSH, payments? If competition is truly able to reduce long-term Medicare costs, shouldn't payments be set on a budget neutral basis compared to the traditional fee-for-service program?

Answer:

Before the MMA, payments to MA plans were inadequate, causing plans to pull out of the program and leaving seniors without a valuable option for receiving their Medicare benefits. In many counties where plans operate, payment rates before the MMA's changes lagged far behind the cost increases faced by plans. Their rates increased by only 2% or 3% compared to much higher health care cost increases. The result was that many enrollees lost important benefits and faced higher cost sharing, and some also faced upheaval when their plan left the program.

Medicare Education/Outreach

Section 1015 of the Medicare prescription drug bill provides CMS with $1 billion for fiscal years 2004 and 2005 to implement the bill. What part of the $1 billion is CMS planning to spend on SHIPs and how will the remaining funds be spent?

Answer:

For FY 04 and FY 05 $21.1 M and $31.7 M respectively were allocated to SHIPs to outreach and educate on the Medicare prescription drug bill, which includes providing one-on-one assistance to enroll individuals into a Medicare drug discount card.

Mental Health and the MMA

- "Dual eligible" patients with mental illness are currently receiving their prescription drug benefits through Medicaid with relatively open access (no restrictive formularies).
- Mentally ill represent less than 20 percent of the dual eligible patient population, and almost 40 percent of dual eligibles' total pharmacy benefit costs. Drugs used to treat disabled mentally ill patients, such as antipsychotic and mood-stabilizing agents, represent the greatest expense for the Medicaid program overall (as compared to other therapeutic areas of treatment).
- Most State Medicaid programs with preferred drug lists (PDLs) and prior authorization requirements have exempted mental illness from these restrictions. Over 30 States with PDLs have some type of exemption for psychotropic medications.
- Evidence-based care for patients with mental illness acknowledges the unique therapeutic value of each of the currently available psychotropic medications used in the treatment of these patients.
- CMS has said that behavioral health and psychological disorders are among a set of conditions for which "prescription drug plans are expected to support current treatment options." This should mean that plans let patients remain on their current medications when the benefit is implemented Jan. 1, 2006.
  a) **How will CMS ensure continuity of care for patients who are currently receiving psychiatric medications?**

     Answer:

     Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

CMS is working to assure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any particular types of beneficiaries. CMS intends to encourage and approve formularies that provide the types of drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories and classes and the formulary list offered are not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building formularies and structuring their bids. CMS will expect plans to recognize the special needs of the mental health patients.

Finally, CMS and the states will provide educational and outreach materials to inform dual eligible beneficiaries of their options under Part D and to assist them in their decision-making processes.

b) **How will CMS ensure that prescription drug plans' formularies reflect best evidence regarding unique therapeutic agents?**

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries.

Plans must use a pharmacy and therapeutic committee including practicing doctors and pharmacists to establish a formulary, so plan enrollees can be assured that they have access to the most effective, up-to-date drugs possible. Plans have the option of using the recently completed model guidelines from US Pharmacopoeia as their formulary classification system or developing their own, but in either case CMS will review the drug chosen to make sure that the formulary is adequate and does not discriminate against certain groups of beneficiaries.

Many States have attempted to restrict access to psychotropic medications and have consistently found the policy to cost more than it potentially saved due to increased utilization of high cost services and increased pharmacy costs related to sub-optimal medication management. Instead, other cost containment strategies are utilized in some states, such as Missouri, and are proven to save money and improve quality of care delivered, without restricting access. How will CMS assure these types of proven quality management, cost containment tools are included in a drug plan's application?

Answer

Drug Utilization Management will be evaluated, as part of the plan's benefit design, to assure equitable application across the enrolled population. Part of the review process for plan's

formulary offerings will include a review of the utilization management criteria such as step-edits and prior authorizations. These reviews will be focused, among other things, on assuring that the plans are not being discriminatory toward any specific disease, diagnosis or patient population. CMS will expect plans to recognize the special needs of the mental health patients.

It is important to note that private health plans have little experience with the mentally ill population, since these individuals are often considered disabled and therefore covered under State Medicaid programs. As such, drug plan applicants will need significant technical assistance to adequately address the needs of the mentally ill population (who are dually eligible for Medicare and Medicaid based on their disability status). A number of agencies within the federal government have medical, clinical and scientific expertise that is directly relevant, including the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health. What role do you envision for these agencies to work in collaboration with CMS to provide expertise?

Answer:

CMS expects that treatment guidelines from these agencies and other respected sources will be an input into plan Pharmacy and Therapeutic committee decision making around issues related to mental health. CMS will check plan formularies to ensure that they support treatment guidelines for a range of diseases, including some mental illnesses. CMS can work with these agencies to provide any additional expertise that plans need in dealing with mental health issues.

LONG-TERM CARE
Transition

Over 65 percent of nursing home residents are dually eligible for Medicaid and Medicare and currently receive prescription drugs under Medicaid, including access to all medically necessary drugs without restrictive formularies. While States have adopted different strategies to control prescription drug costs (e.g., prior authorization and preferred drug lists), the statute limits States' ability to impose restrictive formularies, particularly for nursing home residents. How will CMS ensure that nursing home residents do not lose access to drugs currently covered by Medicaid in the transition to Medicare?

Answer:

CMS will review Part D plan formularies to ensure that they offer a comprehensive array of drugs. As part of the review of plan formularies, CMS will also review plans' strategies to transition beneficiaries who are using a non-formulary drug upon enrollment to ensure that beneficiaries receive clinically-appropriate care. In addition, plans will have to have timely exceptions processes to allow access to non-formulary drugs. Using these approaches, CMS will make sure that all beneficiaries (including LTC residents) receive appropriate, continuous coverage of the drugs they need.

Leavitt Confirmation
Bingaman Questions for the Record

Pharmacy Services

Part D was designed for an "ambulatory" population, and not with nursing home beneficiaries in mind. Unlike you and me, nursing home residents cannot get up and go to an "in network" pharmacy to get their drugs. Instead, a LTC pharmacy services the nursing home, consistent with standards of care and federal and state regulations that have evolved over the years. Services provided include 24/7 delivery, IVs, "stat" or emergency delivery, and drug reviews. The MMA regulations so far do not ensure that PDPs reimburse LTC pharmacies for these specialized pharmacy services. What assurances can you give us that CMS will adequately review PDP applications to ensure that PDPs are committed to providing, and paying for, these services?

Answer:

The final rule requires Part D plans to provide convenient access to covered Part D drugs for beneficiaries residing in long term care facilities. CMS recognizes the specialized pharmacy services that LTC residents require.

Access to OTCs and Benzo's

Benzodiazepines

Approximately 10 percent of nursing home residents receive this class of drugs. Patients are at high risk of destabilization when benzodiazapine therapy is interrupted or changed in the absence of a clinically valid reason.

Over-the-counter: Many OTC drugs are a necessary adjunct to maximize the benefit from prescription agents. When OTC drugs are necessary in combination with prescriptions, there is risk of therapeutic failure when the prescription is used alone. For example, iron supplementation is used with anemia treatment, calcium supplementation is used with certain osteoporosis therapies, acetaminophen is the first line therapy for some pain treatment.

The definition of a "covered Part D drug," excludes benzodiazepines, barbiturates, over-the-counter (OTC) drugs, and weight loss drugs. What will CMS do to encourage State Medicaid programs to ensure access to drugs not covered under the standard Part D benefit? Will CMS consider approving PDPs that cover these excluded drugs, perhaps as a supplemental benefit?

Answer:

All states currently have the option to provide these drugs. CMS is reassuring states that their Medicaid programs will continue to receive federal financial participation (FFP) for the drugs not covered under the Part D benefit. Additionally, CMS will work with states who have SPAPs to help them coordinate their benefits with the new PD plans.

HIV/AIDS

On January 1, 2006, over 60,000 HIV positive people currently receiving comprehensive, affordable and guaranteed prescription coverage through Medicaid will be transitioned to the Medicare Part D prescription drug benefit. What will you do as Secretary of HHS to ensure that there is continuity of care, which is essential for people with HIV, and, secondly, that the benefit they receive on January 1, 2006 provides no less than the comprehensive, affordable and guaranteed prescription drug coverage they currently receive?

Answer:

CMS will work with SSA, states, and other partners to educate all low-income beneficiaries (including dual eligibles) about their coverage choices under the new Medicare drug benefit.

In addition, the CMS formulary review will ensure that plans have a comprehensive array of drugs that reflects best practices in the pharmacy industry as well as current treatment standards on their formulary. CMS would expect plan formularies to provide coverage that supports current medical practice, and thus ensure that HIV positive beneficiaries have access to comprehensive drug coverage, and with the application of the low-income subsidy, these individuals will have a benefit that continues to be affordable.

The Medicare prescription drug benefit, Medicare Part D, will need to be comprehensive and consistent across geographical regions and across plans and accessible, in order to keep people with HIV/AIDS healthy and avoid the development of resistant virus and treatment failure. As Secretary of HHS, what steps will you take to ensure that Private Drug Prescription plans meet the requirements set up through the Medicare Part D regulations so that all medically necessary drugs will be provided?

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries and that vulnerable groups are not discriminated against in drug selection or through co-pays.

Per a requirement in the MMA, CMS requested the U.S. Pharmacopeia (USP) to develop a model set of guidelines consisting of a list of drug categories and classes that may be used by plans to develop formularies for their Part D coverage, including their therapeutic categories and classes. The USP listing will simply serve as a model set of guidelines, however. Plans will have the flexibility to develop their own formulary classification schemes. However, to the extent that a PDP sponsor or MA organization offering an MA-PD plan designs its formulary using therapeutic classes and categories that vary from the USP classification model, CMS will

evaluate the submitted formulary design to ensure that it does not substantially discourage enrollment by certain Part D eligible individuals.

Medicare Wheelchair Benefit

During the last year CMS issued and then rescinded coverage policy for wheelchairs that was both overly restricted and antiquated. It said Medicare would only purchase a power wheelchair when a beneficiary: a. would "otherwise be bed or chair confined", and, b. needed a wheelchair to move around the 4 walls of their home – aka the "in the home rule". In your opinion, is the "in the home" restriction a medically and socially appropriate one for Medicare to enforce with regard to mobility device coverage?

Answer:

Section 1861(n) of Title 18 of the Social Security Act states that the power wheelchair is for use in a patient's home. The "in home" restriction means that for DME, such as a wheelchair, to be covered, a beneficiary must have a medical need to use the DME in the home. This requirement excludes DME from coverage if there is only a medical need to use the equipment outside of the home. However, if DME is medically necessary in the home and the beneficiary also uses it outside of the home, the equipment would still be covered.

The guidance also explicitly says that Medicare will not buy a wheelchair for someone that needs it for use exclusively outside their home, i.e., long distances to shop, go to a doctor or return to work someday. After months of pressure from beneficiaries, health care professionals, the disability and aging communities as well as the wheelchair industry, CMS withdrew this piece of guidance. On December 15th CMS announced that it plans to issue a National Coverage Determination regarding wheelchairs in the next 9 to 12 months. CMS recently signaled a willingness to determine the medical necessity of mobility devices based on functional criteria. Will you assure that such criteria take into account beneficiaries' need to function outside of the four walls of their home?

Answer:

Section 1861(n) of Title 18 of the Social Security Act states that the power wheelchair is for use in a patient's home. The "in home" restriction means that for DME, such as a wheelchair, to be covered, a beneficiary must have a medical need to use the DME in the home. This requirement excludes DME from coverage if there is only a medical need to use the equipment outside of the home. However, if DME is medically necessary in the home and the beneficiary also uses it outside of the home, the equipment would still be covered.

Medicaid Coverage of Pregnant Women

For the first time in many years, our nation's infant mortality rate has increased. The United States ranks 28th in infant mortality and 21st in maternal mortality, the worst among developed nations. Studies with respect to the previous expansions of Medicaid

coverage to pregnant women and children during the Reagan and Bush Administrations indicate those expansions reduced infant mortality and improved child health.

The Bush Administration is providing states, including New Mexico, waivers to cover childless adults with funding intended for children's health through the Children's Health Insurance Program (CHIP). Would you support an option for states to cover pregnant women at the same level of poverty as newborns?

Answer:

Current mandatory coverage levels for pregant women and infants are the same. While states have the option to raise their coverage levels only for pregnant women or for infants, under current federal law, they certainly can keep the eligibility levels for the two groups the same and most have done so.

Implementation of the Reimbursement Provision for Undocumented Immigrants

Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, provides $250 million per year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens. What will you do to assure that the requirements for reimbursement for delivering emergency services to undocumented immigrants are not overly burdensome on health providers?

Answer:

The use of medical services by undocumented immigrants is a significant public health issue for health care providers, particularly those located in states along the U.S-Mexico border, like New Mexico. As required by the Emergency Medical Treatment and Labor Act (EMTALA), hospitals participating in the Medicare program must medically screen all persons seeking care in hospital emergency departments, and provide the treatment necessary to stabilize those determined to have an emergency condition, regardless of income, insurance, or immigration status. I understand that Section 1011 of the MMA is intended to provide relief to hospitals, physicians, and ambulance suppliers who often must absorb the cost of this care.

I understand that the Centers for Medicare & Medicaid Services issued a proposed implementation plan for Section 1011 and the agency has been closely reviewing the many comments submitted in response to that proposed plan. If confirmed as Secretary, I will work with CMS to ensure that Section 1011 is implemented effectively and efficiently.

Obesity

Overweight and obesity are major risk factors for heart disease and stroke, two of the top three leading causes of death in the United States. There have been many alarming reports about the rate at which Americans are becoming obese. A Surgeon General's report has called this problem an epidemic. Recent estimates indicate the direct medical cost

attributable to overweight and obesity is $78 billion dollars annually. And approximately half that amount, about $40 billion, is paid for with public dollars through the Medicare and Medicaid programs. What do you think is the role of the Secretary of Health and Human Services in getting this problem and these costs under control?

Answer:

Seven of nine of the major causes of death in the U.S. are caused by chronic diseases. The underlying causes of these diseases are often behaviors that can be successfully modified thereby reducing illness and death. Three factors-lack of physical activity, poor nutrition, and tobacco use -are major contributors to the nation's leading killers; heart disease, cancer, stroke, chronic obstructive pulmonary disease and diabetes. Too, the prevalence of overweight has more than doubled in children and tripled in adolescents; indicators suggest that diabetes too is increasing among children. This is particularly troubling given obesity is a co-morbidity factor leading to significantly increased risk of death due to cancer, heart disease and diabetes.

In June 2002, President Bush launched the *HealthierUS* initiative to utilize the combined expertise of the federal government to help Americans live longer and healthier lives through simple changes in their everyday lives. The four pillars of the *HealthierUS* initiative are: 1) be physically active every day; 2) eat a nutritious diet; 3) get preventive screenings; and 4) make healthy choices concerning alcohol, tobacco, drugs and safety.

HHS is currently engaged in a number of key activities, two of which are listed below. I look forward to examining what has been done and what is underway, and working to continue this tremendous progress.

Current Activities:

- *Steps to a HealthierUS* Initiative (*Steps*). *Steps* specifically targets diabetes, asthma and obesity. In FY2003 *Steps* funded 23 communities. In FY2004 the program awarded $44 million to help 16 additional communities develop action plans to implement programs that promote disease prevention and health; the total number of funded communities is 40. *Steps* also received $1.5 million to fund one national program, YMCA's Activate America. FY2005 appropriations budget for *Steps* is approximately $47 million.
- National Coverage Decision - Earlier this year, HHS announced a new Medicare coverage policy that would permit Medicare to cover anti-obesity interventions if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes. The new policy removes language in the Medicare Coverage Issues Manual stating that obesity is not an illness, allowing Medicare to determine if specific obesity-related treatments should be covered by Medicare.

Child Care

Since 2001, many states have cut back eligibility for child care assistance and raised co-payments for the families who continue to be eligible for help. Waiting lists for child care

assistance continue to grow. Federal child care funds have been frozen for the past three years. In FY 05, the Child Care Development Block Grant (CCDBG) was frozen at $2.1 billion in discretionary funds, and approximately $2.7 billion in mandatory funds. OMB projections indicated cuts in discretionary funding from FY 06 through FY 09. Accordingly, at least 300,000 children could lose child care assistance over the next several years. Some analysts believe that this number substantially understates the actual number of children who would lose care. Considering the likely decline in the amount of TANF funds that states will be able to commit to child care over the next few years, the number of children receiving child care could decline by almost 450,000 between FYs 03 and 09.

With these projections in mind, how can families achieve self-sufficiency and independence through work without the child care help they need to ensure that their children are safe and well cared for? Considering that the Senate passed a $6 billion increase in mandatory funding for child care over 5 years in a very strong bipartisan vote last year, what would you advocate for in terms of increased funding for child care?

Answer:

Over the last eight years, the welfare caseload has dropped nearly 55% and yet states are receiving the same block grant amounts. Even adjusting for inflation, this means there is substantially more TANF money available for child care and other work supports than when TANF was created in 1996. These amounts are in addition to the $4.8 billion in federal funding available annually through the Child Care and Development Fund. Moreover, the President's plan would allow any carryover funds to be used for child care and other TANF-related purposes; it would end the current restriction that carryover funds only be used for (cash) assistance.

The game of baseball has been tarnished by the use of steroids. Unfortunately, this not only affects the current players taking these substances, but also sends the wrong message to our children. I was in a recent discussion with the Surgeon General who talked about the serious adverse effects of using steroids, including liver disease or even shortening a user's life. That's an important message that many athletes and children aren't hearing. Can you briefly describe the affects of steroid use on the human body? How important is it to keep individuals from using these substances?

Answer:

According to the National Institute of Health's National Institute on Drug Abuse (NIDA), anabolic steroids are legally available in the United States (U. S.) only by prescription and are distinct from steroidal dietary supplements. Until recently, in the U. S., dietary supplements such as androstenedione (Andro) could be purchased legally without a prescription through many commercial sources including health food stores. On October 22, 2004, the President signed "the Anabolic Steroid Control Act of 2004" (Public Law 108-358). This statute, effective January 20, 2005, defines Andro, and many other steroid precursors that had been used as dietary supplements, as controlled substances.

According to NIDA, the health consequences associated with anabolic steroid abuse include:

- *In boys and men*, reduced sperm production, shrinking of the testicles, impotence, difficulty or pain in urinating, baldness, and irreversible breast enlargement (gynecomastia).

- *In girls and women*, development of more masculine characteristics, such as decreased body fat and breast size, deepening of the voice, excessive growth of body hair, and loss of scalp hair, as well as clitoral enlargement.

- *In adolescents of both sexes*, premature termination of the adolescent growth spurt, so that for the rest of their lives, abusers remain shorter than they would have been without the drugs.
- *In males and females of all ages*, potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension, each of which can promote heart attack and stroke; and acne. Although not all scientists agree, some interpret available evidence to show that anabolic steroid abuse-particularly in high doses-promotes aggression that can manifest itself as fighting, physical and sexual abuse, armed robbery, and property crimes such as burglary and vandalism. Upon stopping anabolic steroids, some abusers experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, reduced sex drive, headache, muscle and joint pain, and the desire to take more anabolic steroids.

- *In injectors*, infections resulting from the use of shared needles or nonsterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

1b) What commitments will you make to use your department to combat steroid use among athletes and particularly among children who want to emulate these players?

Answer:

The Anabolic Steroid Control Act of 2004 (Public Law 108-358) authorizes the Department of Health and Human Services (HHS) to award grants to public and nonprofit private entities to carry out science-based education programs in elementary and secondary schools in order to highlight the harmful effects of anabolic steroids. Further, the bill directs HHS to include a question on the use of anabolic steroids in the National Survey on Drug Use and Health. HHS will work to implement the requirements in the new law and thereby reduce abuse of anabolic steroids and improve the public health.

It is my understanding that the National Institutes of Health is working on a proposal that would request researchers receiving NIH funding to submit a copy of their research to NIH so that it can be accessed though a web site by the public.

Do you know when this proposal will be ready for announcement?

Have you had time to look into this issue? If so, what are your thoughts on it?

Answer:

I am not familiar with the details of the proposal, or of where NIH stands as it works to finalize the proposal. Nonetheless, in general, I believe that encouraging transparency and a public dialogue in managing the taxpayer's investments at NIH are critical steps to ensuring that the trust Congress has shown is maintained. And I believe that ensuring that taxpayer-funded research is publicly available is a good step in this effort.

Leavitt Confirmation
Conrad Questions for the Record

Drug Benefit Implementation

I think there are several lessons to be learned from the drug discount card as HHS and CMS implements this new drug benefit. Every time I go back home, a senior will stop me and list the many faults of the drug card – too many choices, not enough stability and insufficient education. If seniors want anything, it's simplicity. HHS needs to do much, much better when we roll out the new drug benefit later this year.

If confirmed, Governor Leavitt, what steps will you take to ensure that this drug benefit is implemented so that seniors and the disabled can understand their options?

Answer:

CMS will work with a broad array of partners to educate people with Medicare, their caregivers and other who help them about the new Medicare prescription drug benefit and other new Medicare benefits and options. CMS will conduct an integrated education campaign and will reach out at the grass roots level to help people with Medicare understand their options to access Medicare prescription drug coverage. This integrated and multi pronged education effort includes simple language fact sheets, more detailed publications including the annual "Medicare & You" handbook, direct mail, community based grassroots efforts to target the different populations with messages directed to their specific needs, e.g., low income, people with retiree drug coverage, 1-800-MEDICARE, www.medicare.gov.

Telemedicine

As co-founder of the Senate Steering Committee on Telehealth and Health Care Informatics, I am pleased that you have shown a strong interest in telehealth. One initiative that I've been working on for a number of years is the National Emergency Telemedical Communications Act. This proposal would create a national emergency telemedical communications network to use telehealth technologies to respond to a terrorist attack or other public health emergency. In working with states on this issue, we have found that existing infrastructure is lacking and that the need for such a network is high.

Governor, I'd like your initial thoughts on such a program. Specifically, can you assure me that you will review my proposal and direct HHS staff to work with me to enact this important legislation?

Answer:

I strongly believe in the potential telehealth has for improving access to health care for millions of Americans, and I commend you for your good work in leading the Senate's telehealth efforts. I look forward to reviewing your proposal and to working with you on this important issue.

Statistics continue to show us that men ignore warning signs of disease and fail to get routine medical check-ups. It should be no surprise to anyone, therefore, that men lead in each of the 15 major causes of death in America except Alzheimer's and have a life span of almost six years shorter than their female counterparts. Given these glaring statistics, do you think that men need an official clearinghouse that coordinates awareness and prevention initiatives, similar to what women have with the Office of Women's Health at HHS?

Answer:

I share your concern about men's health. And I understand that you have expressed increased interest in providing greater emphasis on men's health issues, including the possibility of setting up an office to address these issues. I also understand that HHS, under the leadership of Secretary Thompson, has lead efforts to address these issues. This issue is critical not only to men, but to families and loved ones of the men that are impacted by health challenges. I look forward to working on this issue, and sincerely appreciate your leadership in this important area.

Beginning January 1, 2006, physicians will face Medicare payment cuts that by 2013 will total 31 percent of present payments and threaten beneficiaries' access to care. More that 300 members of the Senate and House have called for the Administration to halt the cuts. I have placed a high priority on resolving this issue. As Secretary, will you make resolving this crisis an HHS priority?

Answer:

I understand that Medicare uses a complex formula to determine the update for physicians. My understanding is that the statutory formula will result in several consecutive years of negative updates for physicians beginning in 2006. While I understand that this is a complicated issue, I haven't gotten into the details of this issue and I'm not prepared to endorse any particular solution today. I would certainly want to see if there are steps that could be taken administratively that could help deal with the issue, and I intend to work on this issue if confirmed.

As you know, one chronic illness is of particular interest to me—Chronic Obstructive Pulmonary Disease, or COPD. To raise awareness of COPD, and the threat it poses to our families and communities, I decided to form the Congressional COPD Caucus, which my colleague Senator Blanche Lincoln joins me in chairing. One important statistic you will probably learn is that annual per capita expenditures for Medicare beneficiaries with COPD are 2.5 times higher than those without COPD. What's more is that while the death rates from heart disease, stroke, and other cardiovascular disease have fallen dramatically over the past thirty years, COPD death rates are on the rise. How can HHS be helpful in slowing this deadly trend? How can we expand prevention and awareness of this 4th leading cause of death in the U.S.?

Answer:

Because of the devastating impact of heart disease, strokes, and cancer today, there is a danger that the impact of COPD and other diseases can be underestimated. I believe that Congress and HHS working together can help increase awareness and slow this trend. You know very well through your Mike Crapo Health Awareness Booths, that the power of awareness and prevention is profound. I applaud your leadership in this area and look forward to working with you to address the impact of this deadly disease.

Senator Orrin Hatch
Questions to ask Mr. Leavitt

1) **The Medicare Modernization Act included a new payment system for the reimbursement of cancer drugs and cancer treatment. Governor, you are sensitive to the importance of community cancer care—especially in America's rural areas—and therefore, please work with Congress to ensure that patient access to appropriate cancer treatment will continue. I have heard from several Utah oncologists who are serious concerned about lower reimbursement rates for their services that they provide to their patients. In addition, they have also raised concerns about lower Medicare reimbursement rates for oncology drugs. I wanted to raise this to your attention and am confident that you will act in the best interest of cancer patients in both rural and urban areas.**

Answer:

I understand that the Medicare Modernization Act significantly changed payment systems for cancer care with payments under a new system taking effect on January 1, 2005. I share your concern and assure you the quality of care for patients with cancer is a major priority for me. It is my understanding the CMS believes there are not widespread access problems to Medicare cancer care. It is also my understanding that it is too early to assess if there may be local areas with access problems. I believe we should monitor access to cancer care, and I intend to work on this issue if confirmed as Secretary.

2) **Helen Croth, former Executive Director of OPTIONS for Independence Center for Independent Living in Logan. She wants OGH to ask Leavitt the following question (which we should submit for the record at SFC): Do you favor eliminating the institutional bias for long-term care from the Medicaid law, and if so, how?**

Answer:

There is more interest now than ever to address ways the Medicaid program is unbalanced toward institutional care. One of the most important ways is removing the institutional bias in the program. Most importantly, the program needs to keep pace with the long-term care needs of an aging population that wants to remain as active and engaged as possible, and it also needs to ensure that people with disabilities are able to contribute to society to the fullest extent to which their abilities permit. And it needs to do this in a way that ensures the long-term viability of the program itself.

When Medicaid started in the 1960s, institutional care was the norm for long-term care services. Now, institutional care remains the best option for many of our most vulnerable citizens with a disability today, but it's simply not the only option for millions of people with a disability. CMS has worked hard with advocacy groups, states, and our other partners to expand consumer options with regard to home and community-based services.

The key concepts here are **beneficiary choice** and **control**. When individuals choose the services that work for them, they make better choices, and that means better outcomes without higher costs. The Administration has been working hard to shift Medicaid's focus – and the President's New Freedom Initiative (NFI) points us in the right direction.

Senator Orrin Hatch
Questions to ask Mr. Leavitt

3) **Governor Leavitt, over the past three years, Congress has struggled- unsuccessfully- to pass a welfare reauthorization bill. As a former governor and one that was extremely involved in creating an effective and efficient welfare program in the State of Utah, I know you will agree with me that states cannot run a successful welfare program that truly helps the poor without having some idea of how much federal assistance will be available to them each year. As you know, there are many states that have not been as successful as Utah in dealing with their welfare caseloads and helping poor Americans find work. As the Secretary of HHS, will you make it a priority to help build consensus around the critical need this nation faces to rewrite its welfare laws and help other states achieve the success Utah has achieved and will you be active in working with the Congress to pass a substantive welfare reform bill?**

Answer:

I share your concern that states should have the confidence that they can make long-term plans to bring welfare reform to the next level of helping poor Americans achieve self-sufficiency through work. As you know, the President's welfare reform reauthorization proposal maintains the commitment made to the Governors in 1996 to provide both the funding and flexibility they need to build on past successes while also strengthening this critical program. Building on these successes, President Bush laid out a clear path for the next phase of welfare reform. The proposal is guided by four critical goals that will transform the lives of low-income families: strengthen work, promote healthy families, give States greater flexibility, and demonstrate compassion to those in need. It has been three years since President Bush first proposed his strategy for reauthorizing TANF and the other critical programs included in welfare reform. During this time, the issues have been debated thoroughly. I believe it is extremely important to finish this work as soon as possible and set a strong, positive course for helping America's families and am willing to work with the Congress to achieve this important goal.

Governor, in the Fiscal Year 2005 appropriations law, funding for child care programs is cut by millions of dollars. Combined with frozen appropriations for years before that, and there are hundreds of thousands of children who have lost federal child care support. This is a terrible outcome for our country. We need to do more to invest in high-quality early childhood care and education for the future of our children, but also to ensure that their parents can rest assured that the children are okay while mom and dad are off working. As I see it, the key is to make sure that high-quality child care is available to make sure that children are ready for school. We have to ensure that support is available not only for families on welfare, but those families that are working and struggling to make ends meet. Can you tell us about your experience with child care in Utah and the future as you see it on a federal level?

Answer:

Utah is committed to making quality, affordable child care available to every child who needs it. Utah strives to support children and families by working collaboratively with providers, employers, agencies, and communities throughout the state to ensure the availability of quality, affordable child care. For example, Utah is currently working on leveraging additional private support for child care, through building a public-private partnership.

Utah is working to ensure that these children receive child care that prepares them to read and succeed in school. State child care administrators are working with early childhood education professionals to develop early learning guidelines that draw on the latest research on how to foster children's readiness for school. Also, quality improvement grants are available to assist child care programs in offering quality services to infants and toddlers and to children in targeted areas across the state.

At the federal level, the combination of TANF, CCDF, SSBG and related funding – totaling $11.5 billion – will continue to provide resources for states to ensure that low-income, working families receive quality child care.

As a result of a deadlock on the debate here in Congress, the welfare law has been extended repeatedly over the course of the last few years. The current extension ends the last day of March. We have been at this over and over again and no matter who is in charge here in the Senate, we can't seem to make much progress. What I think this issue needs is a breath of fresh air. The proposal the administration laid down a few years ago has not brought the Congress together. I think it may be time to start over. We have new data and information about welfare reform and we have new information about poverty in the United States. Can we look forward to a new proposal from HHS that addresses what we know now and works to bring the congress together?

Answer:

The President's plan to build upon the successes of the 1996 welfare reform law was announced nearly three years ago. The goals of the plan were to help more welfare recipients achieve independence through work, promote strong families, empower States to seek new and imaginative solutions to help welfare recipients achieve independence, and show compassion to those in need. The strategy for achieving those goals was a key combination of maintaining successful policies, increasing state flexibility, and providing a renewed emphasis on work as the key to family self-sufficiency. The President's vision for welfare reform was adopted twice by the House of Representatives but, regrettably, has had a more difficult path in the Senate. It is my intention to continue the tremendous efforts of Secretary Thompson to work with you, Chairman Grassley and the other members of the committee so that a good bill can be brought to the Senate floor and approved with the broad support of the Senate.

Plainly and simply, President Bush's goal, Secretary's Thompson's goal, my goal, is the same as that of every member of this committee: to treat those in need with compassion and respect and to help those barely subsisting on welfare to achieve the dignity of work that leads to self-sufficiency. I hope and trust that the House and Senate will be able to pass welfare reform this year, and I look forward to working with you to do so.

Over the last few years, the Centers for Medicare and Medicaid Services (CMS) has been consumed with the reducing the use of power wheel chairs by the programs' beneficiaries. In 2003, then Administrator Scully announced a "10-point initiative to substantially curb abuse of the Medicare program by unscrupulous providers of power wheelchairs"; and last year Dr. McClellan announced a new, "three-pronged approach focused on coverage, payment and quality of suppliers of power wheelchairs".

I am aware that there has been tremendous growth in the reimbursement of these chairs and that CMS has significant concerns about abuse of this benefit. Clearly the agency must guard against fraud and abuse. I have heard from beneficiaries, vendors and health care providers in Vermont who are concerned that these efforts may limit access for those with legitimate needs. I want to alert you to the importance of this equipment to beneficiaries, especially rural-based beneficiaries,.

CMS' current interpretation ignores the very real medical and community living needs of those with disabilities and, as such, it lacks legitimacy in the clinical community. The new national coverage policy for power wheelchairs must provide prescribing physicians and beneficiaries with objective criteria for deciding when a manual or power wheelchair is medically necessary, making it possible to carry the policy out in a fair and consistent manner (a feature which is sorely lacking in the current policy).

I would like a commitment from you that as the CMS moves toward a national coverage decision, that it be based on current best practices in medical and patient care.

Answer:

On December 15, 2004, CMS opened an NCD on mobility assistance devices to examine and set the clinical criteria for the provision of wheelchairs. Based on the recommendations of the federal workgroup of clinicians who have practical experience prescribing wheelchairs -the Interagency Wheelchair Work Group (IWWG), CMS proposed to replace the historical "bed or chair confined" standard with function-based clinical criteria for mobility assistance device (MAD) prescribing. The MMA-required NCD process specifies a proposed decision no later than 6 months after the NCD opens and a final decision posted no later than 9 months after the NCD is initiated.

Last December, the FDA's Independent Expert Advisory Committees were unanimous in their determination that Plan B is safe enough for over-the-counter use, and that there is no data to show that Plan B leads to substitution of emergency contraception for other methods of contraception. Despite this determination by the Advisory Committees, the FDA denied Plan B Over-The-Counter status and overrode the overwhelming scientific evidence.

I am concerned that the FDA decision was based more on ideology than science. Governor Leavitt I am interested in what actions you would take to ensure that FDA decisions are based on scientific evidence and not political ideology?

Answer:

I am committed to the principle that regulatory decisions should be based on the best scientific information that is available. As you know, the FDA previously denied an application to change this drug to over-the-counter status, because adequate data were not provided to support a conclusion that young adolescent women can safely use Plan B for emergency contraception without the professional supervision of a licensed practitioner.

I understand that the sponsor has subsequently submitted a new application, and that the application is being reviewed by the scientists at FDA – and that action is due on this application soon.

In August of 2004, the Drug Enforcement Administration (DEA) forwarded a petition to reschedule marijuana to the Department of Health and Human Services (HHS). The DEA requested from HHS a scientific and medical evaluation of marijuana, upon which it would base its decision as to whether to reschedule

marijuana. By law, the Secretary of HHS is required to conduct this evaluation "within a reasonable time."

As you may know, 10 states, including my home state of Vermont, currently allow for the medical use of marijuana, while the federal government does not. To address this discrepancy, the HHS evaluation needs to move forward. Governor Leavitt, can you work to ensure that this evaluation is completed by August 2005, one year after the request was received by HHS? If not, could you please explain what you would consider a "reasonable time" for this evaluation to be?

Answer:

FDA is currently reviewing the scientific data and must conduct a scientific and medical evaluation of marijuana in accordance with the statutory criteria and make a recommendation to DEA. We will make every effort to complete the evaluation by August 2005.

The state and local public health laboratories represent the backbone of any emergency response to naturally occurring or induced disasters and they have spent the past five years working to improve their capability and capacity to respond. While progress has been made in many areas, such as the ability to respond to an anthrax attack and to test human samples, much work remains before we can assure the American people that we are prepared for incidents that involve environmental samples (those that do not come from humans), particularly in a chemical, radiological, or nuclear attack. In fact, today, we are woefully unprepared to test these environmental samples.

Can you please explain how you plan to address the unmet need of providing state laboratories with the capability to test environmental samples for terrorist agents so they can appropriately respond to a "dirty bomb" involving multiple hazards or to a chemical terrorist event?

Finally, how will you better coordinate the federal departments within Health and Human Services (Food and Drug Administration; Centers for Disease Control and Prevention) and across federal agencies (Department of Defense; Department of Homeland Security; Environmental Protection Agency) to advance the nation's public health laboratory emergency preparedness?

Answer:

I agree that state and local public health laboratories are essential to ensuring effective responses to bioterrorism and other public health emergencies. They are the core participants in the HHS-led Laboratory Response Network (LRN), which is among the

most significant achievements resulting from the expanded HHS investments in state and local preparedness that followed the terrorism events of the fall of 2001.

Building upon its strong base for testing human clinical samples for the presence of biological and chemical threat agents, the LRN is working to enhance its capabilities for testing environmental samples. In the course of providing the analytical support for Project Biowatch (the monitoring system for possible outdoor release of bioterrorism threat agents), LRN participants have developed high proficiency in the use of rapid test methods for biological agents in environmental samples. The LRN is working to make comparable gains with respect to chemical agents in environmental samples.

With respect to testing environmental samples associated with detonation of a radiological dispersion device ("RDD") or "dirty bomb", the recently issued Federal Response Plan assigns the primary responsibilities to the Department of Energy (DOE) and the Environmental Protection Agency (EPA). In particular, the DOE "Provides, in cooperation with other Federal agencies, the personnel and equipment to perform radiological monitoring and assessment activities, and provides onscene analytical capability supporting assessments"; whereas EPA "Provides resources, including personnel, equipment, and laboratory support (including mobile laboratories) to assist DOE in monitoring radioactivity levels in the environment." HHS, of course, will support DOE and EPA in their respective roles as best we can.

With respect to coordination of its own agencies and those of other parts of the Executive Branch, HHS will continue to strengthen and expand the LRN while ensuring effective collaboration with other laboratory networks, especially those that support food and agricultural security, environmental protection, and national defense.

Leavitt Confirmation
Kyl Questions for the Record

Bioterrorism / Emergency Preparedness

Today, we discuss the threats of bioterrorism, threats to our food and water supply, and the possible infiltration of harmful substances into our drug supply if we import drugs from outside of the United States. As a member of the Judiciary Committee and Chair of the Subcommittee on Terrorism, Technology and Homeland Security, I am greatly concerned about the emergency preparedness and our ability to respond to biological threats. Preparing for an attack or responding to domestic disasters will require the coordination of many agencies.

How do you think the government can collaborate and plan, both on the federal level and with the states, to respond in the event of a terrorist attack or an epidemic?

Answer:

Bioterrorism preparedness is an ongoing priority and effort by the Federal government. Since 2001, the federal government has made $4 billion available for state, local and hospital preparedness. Although we have made substantial gains in the past few years, I will make it a priority to continue these efforts, including to ensure that necessary funding is made available. To this end, I would note that significant sums of money are still available to the states, who have not drawn down these funds. This is disappointing to me, and I will make it a priority to do everything possible to encourage states to utilize the resources that are available to them.

Moreover, in February 2002, I had the honor of hosting the XIX Winter Olympics in Salt Lake City, Utah. In the months and years leading up to the Olympics, my State learned the value of cooperative planning and operations across all disciplines and levels of Government. As you may recall, the 2002 Olympics were the first to be held in the post September 11 world. This made the event even more challenging and complicated than usual. As Governor, I was well aware of the need to coordinate across all levels of government and the private sector, including the transportation industry, public safety organizations, the chamber of commerce, numerous public and private venues and the public health and medical community. This cooperative planning process resulted in a well coordinated effort in this incredible international sporting event.

As the Secretary of HHS, I will draw from my experiences in Utah in managing the complex events and emergencies that face this organization. Many of the principles I learned through the Olympic experience can and should now be used in our approach to State and local public health and medical preparedness efforts. By leveraging the assets of neighboring towns, counties, States and the Federal Government, we can achieve more effective prevention, preparedness, response and recovery from even the most significant disasters.

Leavitt Confirmation
Kyl Questions for the Record

Scientific Research / NIH

One of the agencies most often discussed around Congress under the Department of Health and Human Services is the NIH, the National Institutes of Health. The research on conditions and drugs has been of tremendous benefit to millions of citizens as well as people all around the world. Congress doubled the NIH budget over 5 years, but there still constant battles about where the funds are used and what conditions are researched. Not being a researcher nor a doctor, I prefer to have those most qualified on the conditions and the science recommend where our emphasis should be, tempering efforts on things that are affecting many people (like cancer and diabetes) with research on some of the most rare diseases that lack any treatment or cure.

Can you comment on NIH and your thoughts on having more of the research directed by the science and research instead of by Congress?

Answer:

I believe that NIH represents a national commitment towards improving our knowledge and treatment of disease. As you know, President Bush completed the doubling of NIH's budget. It is my intention to work with NIH to ensure that this commitment is maintained and strengthened. Nonetheless, I agree that NIH can improve its transparency, and look forward to working with Congress and with NIH to accomplish just this and to ensure that its research is directed by the science.

Senator Jon Kyl
Questions to ask Mr. Leavitt
(Medicare Reimbursement for Physician Services)

As you know, I feel very strongly about the need to appropriately pay for quality medical care. The Medicare program is full of arbitrary payment mechanisms without much rhyme and reason and seems to always be years behind the market in adequately paying healthcare providers.

1) **How do we address the need to appropriately and adequately pay for quality medical care when providers, specifically hospitals and physicians, are constantly threatened with reimbursement cuts?**

Answer:

Medicare needs to move away from a system that pays simply for more services, to a system that encourages and rewards efficiency and high quality care. Focusing on higher quality and efficiency will help reduce avoidable health care costs. Physicians are in the best position to know what works to improve their practice of medicine and should be closely involved in helping us establish payment methodologies that support those efforts.

CMS is working closely and collaboratively with medical professionals and the Congress to consider changes to increase the effectiveness of how Medicare compensates physicians for providing services to Medicare beneficiaries. To that end, CMS is engaging physicians in establishing quality and performance measures.

Although CMS is working toward a more efficient payment system, they remain concerned about, the current volume-based payment system for physicians' services. As you know, this system is currently projected to result in seven years of negative updates in physician payments. Yet simply adding larger updates into the current payment system would be extremely expensive from a financing standpoint, and would not promote better quality care. There are now significant variations in resources and spending growth for the same medical condition in different practices and in different parts of the country, without apparent difference in quality and outcomes. The current system is not designed to address those issues on an individual physician level. CMS is committed to working with Congress and the medical community to remedy this situation and is doing what it can administratively to develop reporting and payment systems that will enable CMS to support and reward quality.

Senator Jon Kyl
Questions to ask Mr. Leavitt
(Medicare Reimbursement for Physician Services)

2) Given the growing needs of our senior population who often face multiple chronic medical conditions, how do healthcare providers meet those demands while maintaining access and quality of care?

Answer:

The Medicare physician spending baseline reflects spending on physicians' services for beneficiaries in the fee-for-service program. Decreases in Medicare physician spending from 2005 to 2010 are relatively small but reflect assumed decreases in the percent of Medicare beneficiaries in the fee-for-service program, as well as reductions in the payment rates under the statutory formula.

3) Can you talk about your intentions as head of Health and Human Services to work with the Administration and Congress towards a permanent fix?

Answer:

Because it is critical for the Medicare physician payment system to support better outcomes for our beneficiaries at a lower cost, we are working closely and collaboratively with medical professionals and the Congress to consider changes to increase the effectiveness of how Medicare compensates physicians for providing services to Medicare beneficiaries. We are engaging physicians on issues of quality and performance with the goal of supporting the most effective clinical and financial approaches to achieve better health outcomes for people with Medicare. At the same time, however, we are concerned and are closely monitoring the current volume-based payment system for physicians' services, which projects seven years of negative updates in physician payments. Simply adding larger updates into the current payment system would be extremely expensive from a financing standpoint, and would not promote better quality care. Under this system, there are significant variations in resources and in spending growth for the same medical condition in different practices and in different parts of the country, without apparent difference in quality and outcomes. We are committed to working with Congress and the medical community to remedy this situation and are doing what we can administratively to develop reporting and payment systems that enable us to support and reward quality.

Leavitt Confirmation
Lincoln Questions for the Record

Medicaid/Legal Immigrants:

Current law requires legal immigrant women who are pregnant to have been in this country five years before they are eligible for coverage under Medicaid. This is not only unfair, but imprudent as a matter of health policy, since these children will be U.S. citizens when they are born and eligible for Medicaid coverage. This policy is also a major burden on our "safety net" health care providers, especially in areas like Northwest Arkansas, which has seen a huge increase in its immigrant population. As a mother of twin boys, I understand the critical role of prenatal care in ensuring a safe delivery as well as giving newborns a healthy start at life. Do you support expanding coverage to pregnant women who are legal immigrants?

Answer:

Extending coverage would be a cost shift from private individuals to the public which should not be encouraged as public policy. The restrictions in Medicaid are based on the legal obligations of the sponsor who brings an individual into the United States to provide for the needs of the person voluntarily seeking entry.

The restrictions on public benefits, including Medicaid, to non-citizens were signed into law by President Clinton and therefore Congress would have to change the law. Medicaid does provide coverage to non-citizens for emergency services.

The current rules for time-limited immigrant financial self-sufficiency and sponsorship generally are reasonable to ensure they will not be an undue burden to the U.S. Providing Medicaid and SCHIP coverage during such time periods would be expensive and contrary to these principles. Instead, the President's FY 2005 budget included a more targeted proposal to extend the refugee/asylee exemption from seven years to eight years, to assure that such individuals have ample time to complete the citizenship process without losing eligibility for benefits for which they otherwise qualify.

Medicaid Family Planning

Currently, 21 States have expanded access to Medicaid family planning services to low-income women who would not otherwise be eligible for Medicaid. Arkansas is one such state; they have extended family planning services to individuals up to 200 percent of the Federal Poverty Level. These programs have been extremely successful in increasing access to family planning and helping women avoid unintended pregnancy – all at a considerable savings to state and federal governments. This is according to a CMS-funded study of expansions programs of six states. I am particularly proud of these results, as my state of Arkansas was one of the six states studied. Will you support state efforts to initiate these Medicaid family planning eligibility expansions?

Answer:

Family planning waivers are examples of a narrowly defined benefit package and one which is often time limited. Medicaid Section 1115 family planning demonstrations extend Medicaid eligibility for family planning services to low-income populations, defined by the state, who are at risk of having unplanned pregnancies. The premise of these demonstrations is that by providing this coverage and allowing enrolled women to obtain services through any provider who accepts Medicaid coverage, access for low-income women is improved and they will utilize these services and reduce pregnancy, resulting in savings in maternity and infant services covered by Medicaid. There are currently twenty one states with Medicaid Section 1115 family planning demonstrations and over 2.4 million people were enrolled in calendar year 2004.

Uninsured

I know that as governor you were interested in trying to cover the uninsured. The Administration's proposal to provide refundable tax credits has not generated any bipartisan support. In addition, the health coverage tax credit that passed as part of Trade Adjustment Assistance in 2002—the only health care tax credit enacted into law to date—has attracted only 6% of those eligible. I understand that as governor you opposed legislation to create federal Association Health Plans (or AHPs), which is also part of this Administration's agenda. Do you still oppose AHPs, and how do you think we should help the 45 million Americans who are uninsured? I have introduced a plan to help small businesses afford health insurance, and I believe it is critical that we work together to solve this growing crisis in a bipartisan way.

Answer:

I understand the benefit of helping small businesses to provide affordable health insurance coverage for their workers by banding together to negotiate on behalf of their employees and their families. And I believe that we need to do everything we can to give America's working families greater access to affordable insurance. The Administration's proposal would increase the number of insured small firm employees and dependents and would produce savings for participating small businesses. One of the concerns about AHPs is that plans would choose to cover only the healthiest workers. However, there are ways to ensure that AHPs pool together a diverse range of health risks and to safeguard against destabilization of the private market. If AHPs are implemented, I am confident that the Department of Labor would effectively administer its certification and oversight responsibilities.

TANF

Welfare reauthorization has been stalled in Congress for 3 years. We are currently operating the program under the 8th extension. Along with many of my colleagues, I have been a part of several bipartisan approaches to reauthorizing the welfare program. The Bush Administration has recommended strict and less flexible

policies that have alienated many law-makers in Congress and on the state level. The emphasis on increasing work hours and participation rates without increasing childcare or other work supports for families has created a roadblock. How do you intend to break this gridlock on welfare reauthorization?

Answer:

I think everyone agrees about the huge success of the 1996 reforms. The 1996 welfare reforms have had a profound impact on our nation's most vulnerable families and have exceeded the most optimistic expectations by assisting millions of families in moving from dependence on welfare to the independence of work. I believe that we can successfully work together to reauthorize the TANF program and the Child Care Entitlement Programs, as well as to make improvements to our Child Support Enforcement program, which will lead to even greater achievements in the future. We can all find common ground in President Bush's proposal for the next phase of welfare reform which is based on four important goals: help more welfare recipients achieve independence through work; promote strong families; empower States to seek new and imaginative solutions to help welfare recipients achieve independence; and show compassion to those in need.

Medicare Dual Eligibles/Gap

According to CMS's proposed rules, Medicare beneficiaries dually eligible for Medicaid ("dual eligibles") are likely to experience a gap of 4.5 months in prescription drug coverage. According to their timetable, duals will be automatically enrolled in the Medicare drug benefit beginning May 15, 2006. However, Medicaid drug benefits will expire January 1, 2006. This gap in coverage is unacceptable–it would have serious health and financial consequences for many beneficiaries. What will you do as Secretary of HHS to ensure these most vulnerable beneficiaries do not experience a gap in drug coverage?

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

CMS is working to assure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any particular types of beneficiaries. CMS intends to encourage and approve formularies that provide the types of drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories and classes and the formulary list offered are

not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building formularies and structuring their bids.

Part D sponsors are required to provide for an appropriate transition process for new enrollees that are prescribed Part D drugs not on their Part D plan's formulary. This transition policy must meet the requirements consistent with written policy guidelines and other CMS instructions.
Should a full-benefit dual eligible individual need to change PD plans to better accommodate his/her pharmaceutical needs and pharmacy affiliations, s/he may do so at any time because of a Special Enrollment Period afforded to them. The Special Enrollment Period allows full benefit dual eligible beneficiaries to switch from one MA-PD plan to another, from one PD plan to another, or from original Medicare and a PD plan into an MA-PD plan and vice versa.

Finally, CMS and the states will provide educational and outreach materials to inform dual eligible beneficiaries of their options under Part D and to assist them in their decision-making processes.

Dual Eligibles/Enrollment:

Does CMS have enough financial resources to provide the one-on-one counseling needed to educate and enroll the low-income population? What if the drugs these beneficiaries need are not covered in Medicare plans? How will states coordinate care for duals without drug data?

Answer:

In addition to its usual partnerships, CMS will rely on an intensive outreach campaign on the benefit.

CMS encourages Part D plans to independently share data on these enrollees with state Medicaid plans, provided such disclosure is consistent with the requirements of the HIPAA Privacy Rule.

Dual Eligibles/Access to Drugs

As proposed in CMS's proposed rule, dual eligibles would be automatically enrolled in the "benchmark" or "average cost" plans in their areas because the low-income subsidy they will receive will only cover the premium for these plans. The formularies for these plans will not be as comprehensive as the drug coverage these individuals currently have through Medicaid. Even in states that have restricted access to drugs in Medicaid programs with preferred drug lists and prior authorization requirements, most of these states have exempted selected conditions, such as mental illness, from these restrictions. Without access to the coverage they need, dual eligibles will be forced to switch medications. In the treatment of

HIV/AIDS, such switches can be deadly. How will CMS ensure continuity of care for all of those with pharmacologically complex conditions?

Answer:

CMS will work with SSA, states, and other partners to educate all low-income beneficiaries (including dual eligibles) about their coverage choices under the new Medicare drug benefit.

In addition, the CMS formulary review will ensure that plans have a comprehensive array of drugs that reflects best practices in the pharmacy industry as well as current treatment standards on their formulary. CMS would expect plan formularies to provide coverage that supports current medical practice, and thus ensure that HIV positive beneficiaries have access to comprehensive drug coverage, and with the application of the low-income subsidy, these individuals will have a benefit that continues to be affordable.

MSP Eligibility Screening

What steps is CMS going to take to make sure that low- income subsidy applicants are also screened for MSP eligibility? It would be a waste to gather so much information on millions of people and not use it to improve enrollment in already existing programs.

Answer:

CMS is working with SSA to design a process to provide subsidy determination information to states through CMS for purposes of identifying individuals who apply at SSA and who may also qualify for a Medicare Savings Program in the State. States may use the determination to contact individuals who may qualify for the MSP.

If a person does apply in person at a State office, the state would be obligated to assist individuals in completing the application for the low-income subsidy and to screen individuals for Medicare Savings Program eligibility.

Medicare Advantage/Quality Improvement

I believe stronger quality improvement initiatives should be required of the Medicare Advantage (MA) plans. The proposed rule states that CMS "would require an organization offering an MA plan to *encourage* its providers to participate in CMS and HHS quality improvement initiatives." Since the taxpayer is paying MA plans more for service to the same population in the traditional fee-for-service program, it is reasonable to require, *rather than merely encourage* stronger quality improvement efforts. Will CMS make quality a priority for all plans?

Answer:

Quality is a priority for all MA plans. The MMA requires that MA plans conduct quality improvement projects - which the plans specify to CMS. Those requirements include the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. In addition, section 1852(e) adds a requirement that MA plans conduct chronic care improvement projects to identify and monitor the needs of such individuals.

Medicare Drug Formularies

Patient groups are concerned with the proposed regulations that address the way in which drug formularies will be developed and modified, how patients will be informed of changes in drug coverage, and how beneficiaries would appeal coverage decisions. All of these issues impact patient access to prescription drugs. How will CMS ensure that beneficiaries have access to all medically necessary drugs, that there is an openness and transparency of processes and procedures with advance notice and ability to comment for the public, and that regulatory protections apply to all potential access restrictions, such as formularies, preferred drug lists, and prior authorization?

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries and that vulnerable groups are not discriminated against in drug selection or through co-pays.

Per a requirement in the MMA, CMS requested the U.S. Pharmacopeia (USP) to develop a model set of guidelines consisting of a list of drug categories and classes that may be used by plans to develop formularies for their Part D coverage, including their therapeutic categories and classes. The USP listing will simply serve as a model set of guidelines, however. Plans will have the flexibility to develop their own formulary classification schemes. However, to the extent that a PDP sponsor or MA organization offering an MA-PD plan designs its formulary using therapeutic classes and categories that vary from the USP classification model, CMS will evaluate the submitted formulary design to ensure that it does not substantially discourage enrollment by certain Part D eligible individuals.

Drug Card

The GAO has said that callers to the 1-800-MEDICARE help line got accurate answers only 61% of the time. Of the remainder, 29% were given erroneous or

incomplete information, and 10% of the calls weren't answered at all, as callers were disconnected. Will you take any steps to correct this? GAO says that the two-week training "is not sufficient to ensure that [representatives] are able to answer questions accurately." Seniors and their families need to have confidence in the new Medicare drug program—it is vital to its success. Seniors are going to be signing up for their drug benefit package this fall.

Answer:

CMS continues to look for ways to improve and build upon the already high level of service provided at 1-800-MEDICARE, and CMS appreciates recommendations that the GAO has provided. The GAO review was a "snapshot" of 420 calls out of the 1.2 million calls received in July 2004 that involved some specific "test" questions asked by GAO reviewers. CMS strongly believes that the findings from these detailed and uncommon questions should not be used to generalize about the performance at 1-800-MEDICARE.

However, CMS understands that the MMA provisions can be complex to understand and CMS is working harder than ever to train call center staff on how to answer the more complex questions. In order to answer some of these more complex, uncommon questions related to the MMA, the reference staff at each call center have been provided materials to handle these inquiries. When appropriate, these types of updated materials are regularly provided to reference staff. Another example of CMS' efforts to implement the GAO recommendations includes the implementation of additional routing plans that ensure callers are not transferred to a site that is closed.

CMS continually monitors services provided at the call center to ensure that the objective of providing clear and accurate responses is being met and to make service improvements when needed. Callers are surveyed regularly and CSRs are monitored to check if beneficiaries are getting the assistance they need. CMS' focus is not whether the "full script" of information is being used, but that beneficiaries receive personalized, responsive answers to their questions and are not overloaded with unnecessary information that may be confusing. CMS continues to employ a variety of methods to ensure the accuracy of information to callers. A majority of scripts have been consumer tested in the development of Medicare publications. In addition, CMS holds regular focus groups to identify ways to explain complex concepts, in an easy to understand manner, to beneficiaries for a variety of purposes. It is true that there is not sufficient time to "test" every script as there are occasions where scripts are developed in response to urgent issues which have become "hot topics".

In order to implement improvements where applicable, CMS has requested and recently received call detail information from the GAO. CMS is in the process of analyzing this data in order to prepare a final response to them.

Stabilization Fund

The MMA included a $12 billion "stabilization fund" to increase payment to Medicare health plans to establish PPOs in areas of the country otherwise not covered. The provision also authorizes the Secretary of HHS to make final decisions on spending money from this fund. Rather than pay health plans, would you as Secretary consider using this money for direct financial incentives to physicians and other health care providers to encourage them to join PPOs in order to ensure that areas normally not covered by health plans do have PPOs as a beneficiary choice?

Answer:

Starting in 2007, the Medicare Modernization Act (MMA) provides for a stabilization fund (initially funded at $10 billion) that will be available to Medicare Advantage regional plans to encourage plan entry and retention across the country. Such funds provided to MA regional plans will be used in various ways, including increasing benefits or increasing provider access, which means MA plans could use this funding to increase their payments to providers. Also, the MMA specifies that $25 million a year be made available to "essential hospitals" that treat regional Medicare Advantage plan enrollees. Acute care hospitals that do not have a contract with a regional Medicare Advantage plan, but which treat Medicare Advantage regional plan enrollees, can be paid an additional amount if they show that their costs for providing care to a Medicare Advantage regional plan enrollee exceeded the amount that Medicare would normally pay for such a service.

Insurance Regulations on MA Plans

Some in the health care community are concerned that regulatory and enforcement activities of individual state insurance commissioners may decrease ultimate effectiveness of the Medicare Advantage programs and plans envisioned by the MMA. As Secretary, would you be attentive to this potential problem and, if necessary, consider rule-making or even legislation which could be necessary to mitigate unnecessary state regulatory activity?

Answer:

As you know, The MMA amended section 1856(b)(3) of the Act relating to federal preemption of state law. That section specifies that federal standards will supersede any state law or regulation other than state licensing laws or state laws related to plan solvency. Prior to this change, federal preemption of state law would not apply, in many areas, unless the relevant state law conflicted with Medicare plan requirements. Nonetheless, I will work with CMS to be attentive to any potential problem in this area.

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Medicare Physician Payments

As you know, the MMA prevented automatic formula cuts to physicians from occurring in 2004 and 2005 and instead provided increases of 1.5 percent. In 2006, the formula, also known as the Sustainable Growth Rate (SGR), kicks in again, and, without Congressional action, will reduce physician payments for the next several years. Proposals in Congress to prevent future cuts are costly. One is estimated to be about $90 billion over 10 years. The majority of Congress wants to fix this problem. What is your position on this issue? Will the administration propose doing anything in its budget this year to fix this problem? Do you agree with MedPAC that physician payments should be tied to improvements in quality of care?

Answer:

I understand that Medicare uses a complex formula to determine the update for physicians. My understanding is that the statutory formula will result in several consecutive years of negative updates for physicians beginning in 2006. While I understand that this is a complicated issue, I haven't gotten into the details of this issue and I'm not prepared to endorse any particular solution today. I would certainly want to see if there are steps that could be taken administratively that could help deal with the issue, and I look forward to working on this issue if confirmed.

Medicare "Cancer Cuts"

Throughout this year, I have heard many complaints from oncologists in Arkansas that the reforms we enacted in the MMA to pay for Part B drugs went too far. In the MMA, Congress not only reformed payment for Part B drugs so it would more accurately reflect the actual costs of purchasing and administrating drugs, but also greatly increased practice expense payments. However, oncologists in my state say that the practice expense formula is unfair to the physicians in Arkansas. They say, for example, that what their practice pays for chemotherapy drugs is exactly what a practice in Florida pays because they both purchase in volume from the same suppliers. They say that the marginal profit they received from these drugs was used to offset the practice expense of administering the drugs and counseling social services.

CMS recognized that certain practice expenses were being under-reimbursed and did increase the reimbursement for seven of these care codes. But there are two problems: 1) this increase is nowhere near the reduction for all practices, and 2) states like Arkansas are reimbursed at lower rates than states like Florida. I have cosponsored legislation in the past to establish a minimum index or floor of 1 for the practice expense component of the physician fee schedule. A floor of 1 would greatly help physicians in Arkansas, because we have some of the lowest geographic practice cost indexes (GPCIs) in the country. Bumping up these GPCIs to 1 will automatically provide more money to Arkansas physicians. In the MMA, we put a

floor of 1 on the work component. Do you believe that we should establish a floor on the other two GPCIs?

Answer:

I understand that the statute requires Medicare physician payment adjustments among areas. I would want to look at the geographic adjustment issue if I were to be confirmed as Secretary.

Obesity Treatments

What do you think HHS should do to combat obesity? Is the Administration considering any review of the policy which substantially limits coverage for weight loss drugs and therapies?

Answer:

Seven of nine of the major causes of death in the U.S. are caused by chronic diseases. The underlying causes of these diseases are often behaviors that can be successfully modified thereby reducing illness and death. Three factors-lack of physical activity, poor nutrition, and tobacco use -are major contributors to the nation's leading killers; heart disease, cancer, stroke, chronic obstructive pulmonary disease and diabetes. Too, the prevalence of overweight has more than doubled in children and tripled in adolescents; indicators suggest that diabetes too is increasing among children. This is particularly troubling given obesity is a co-morbidity factor leading to significantly increased risk of death due to cancer, heart disease and diabetes.

In June 2002, President Bush launched the *HealthierUS* initiative to utilize the combined expertise of the federal government to help Americans live longer and healthier lives through simple changes in their everyday lives. The four pillars of the *HealthierUS* initiative are: 1) be physically active every day; 2) eat a nutritious diet; 3) get preventive screenings; and 4) make healthy choices concerning alcohol, tobacco, drugs and safety.

HHS is currently engaged in a number of key activities, two of which are listed below. I look forward to examining what has been done and what is underway, and working to continue this tremendous progress.

Current Activities:

- *Steps to a HealthierUS* Initiative (*Steps*). *Steps* specifically targets diabetes, asthma and obesity. In FY2003 *Steps* funded 23 communities. In FY2004 the program awarded $44 million to help 16 additional communities develop action plans to implement programs that promote disease prevention and health; the total number of funded communities is 40. *Steps* also received $1.5 million to fund

one national program, YMCA's Activate America. FY2005 appropriations budget for *Steps* is approximately $47 million.

- National Coverage Decision - Earlier this year, HHS announced a new Medicare coverage policy that would permit Medicare to cover anti-obesity interventions if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes. The new policy removes language in the Medicare Coverage Issues Manual stating that obesity is not an illness, allowing Medicare to determine if specific obesity-related treatments should be covered by Medicare.

Weight Loss Drugs

Do you believe Congress should revisit its apparent decision to preclude coverage for medically necessary weight loss drugs under Part D for either the treatment of obesity or the co-morbidities it causes? In the absence of congressional action, do you think that HHS possesses the inherent authority to cover medically necessary pharmaceutical treatments for obesity under Part D?

Answer:

The new Medicare coverage policy enables Medicare to review scientific evidence in order to determine which interventions improve health outcomes for seniors and disabled Americans who are obese. Medicare would only cover treatments for obesity-related illnesses if there is evidence that such treatments are effective for the Medicare population.

Access to Mental Health Drugs

CMS has said that behavioral health and psychological disorders are among a set of conditions for which "prescription drug plans are expected to support current treatment options." This should mean that plans let patients remain on their current medications when the benefit is implemented Jan. 1, 2006.

a) **How will CMS ensure continuity of care for "dual eligible" patients who are currently receiving psychiatric medications?**

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

CMS is working to assure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any particular types of beneficiaries. CMS intends to encourage and approve formularies that provide the types of drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories and classes and the formulary list offered are not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building formularies and structuring their bids. CMS will expect plans to recognize the special needs of the mental health patients.

Finally, CMS and the states will provide educational and outreach materials to inform dual eligible beneficiaries of their options under Part D and to assist them in their decision-making processes.

b) How will CMS ensure that prescription drug plans' formularies reflect best evidence regarding unique therapeutic agents?

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries.

Plans must use a pharmacy and therapeutic committee including practicing doctors and pharmacists to establish a formulary, so plan enrollees can be assured that they have access to the most effective, up-to-date drugs possible. Plans have the option of using the recently completed model guidelines from US Pharmacopoeia as their formulary classification system or developing their own, but in either case CMS will review the drug chosen to make sure that the formulary is adequate and does not discriminate against certain groups of beneficiaries.

Access to OTCs and Benzodiazepine

The definition of a "covered Part D drug," excludes benzodiazepines, barbiturates, over-the-counter (OTC) drugs, and weight loss drugs. What will CMS do to encourage State Medicaid programs to ensure access to drugs not covered under the standard Part D benefit? Will CMS consider approving PDPs that cover these excluded drugs, perhaps as a supplemental benefit?

Answer:

All states currently have the option to provide these drugs. CMS is reassuring states that their Medicaid programs will continue to receive federal financial participation (FFP) for the drugs not covered under the Part D benefit. Additionally, CMS will work with states who have SPAPs to help them coordinate their benefits with the new PD plans.

Psychotropic Medicines

Many States have attempted to restrict access to psychotropic medications and have consistently found the policy to cost more than it potentially saved due to increased utilization of high cost services and increased pharmacy costs related to sub-optimal medication management. Instead, other cost containment strategies are utilized in some states, such as Missouri, and are proven to save money and improve quality of care delivered, without restricting access. How will CMS assure these types of proven quality management and cost containment tools are included in a drug plan's application?

Answer:

Drug Utilization Management will be evaluated, as part of the plan's benefit design, to assure equitable application across the enrolled population. Part of the review process for plan's formulary offerings will include a review of the utilization management criteria such as step-edits and prior authorizations. These reviews will be focused, among other things, on assuring that the plans are not being discriminatory toward any specific disease, diagnosis or patient population. CMS will expect plans to recognize the special needs of the mental health patients.

Technical Assistance for Patients

It is important to note that private health plans have little experience with the mentally ill population, since these individuals are often considered disabled and therefore covered under State Medicaid programs. As such, drug plan applicants will need significant technical assistance to adequately address the needs of the mentally ill population (who are dually eligible for Medicare and Medicaid based on their disability status). A number of agencies within the federal government have medical, clinical and scientific expertise that is directly relevant, including the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health. What role do you envision for these agencies to work in collaboration with CMS to provide expertise? What other methods will CMS employ to combat this potential problem?

Answer:

CMS expects that treatment guidelines from these agencies and other respected sources will be an input into plan Pharmacy and Therapeutic committee decision making around issues related to mental health. CMS will check plan formularies to ensure that they support treatment guidelines for a range of diseases, including some mental illnesses. CMS can work with these agencies to provide any additional expertise that plans need in dealing with mental health issues.

Dual Eligibles

Over 65 percent of nursing home residents are dually eligible for Medicaid and Medicare and currently receive prescription drugs under Medicaid, including access to all medically necessary drugs without restrictive formularies. While States have adopted different strategies to control prescription drug costs (e.g., prior authorization and preferred drug lists), the statute limits States' ability to impose restrictive formularies, particularly for nursing home residents. How will CMS ensure that nursing home residents do not lose access to drugs currently covered by Medicaid in the transition to Medicare?

Answer:

CMS will review Part D plan formularies to ensure that they offer a comprehensive array of drugs. As part of the review of plan formularies, CMS will also review plans' strategies to transition beneficiaries who are using a non-formulary drug upon enrollment to ensure that beneficiaries receive clinically-appropriate care. In addition, plans will have to have timely exceptions processes to allow access to non-formulary drugs. Using these approaches, CMS will make sure that all beneficiaries (including LTC residents) receive appropriate, continuous coverage of the drugs they need.

Pharmacy Services

Part D was designed for an "ambulatory" population, and not with nursing home beneficiaries in mind. Unlike you and me, nursing home residents cannot get up and go to an "in network" pharmacy to get their drugs. Instead, a LTC pharmacy services the nursing home, consistent with standards of care and federal and state regulations that have evolved over the years. Services provided include 24/7 delivery, IVs, "stat" or emergency delivery, and drug reviews. The MMA regulations so far do not ensure that PDPs reimburse LTC pharmacies for these specialized pharmacy services. What assurances can you give us that CMS will adequately review PDP applications to ensure that PDPs are committed to providing, and paying for, these services?

Answer:

The final rule requires Part D plans to provide convenient access to covered Part D drugs for beneficiaries residing in long term care facilities. CMS recognizes the specialized pharmacy services that LTC residents require.

Physician-Owned Limited Facilities (Specialty Hospitals)

The MMA included an 18-month moratorium on the construction of new "specialty hospitals," which expires on June 8, 2005. The MMA required both MedPAC and HHS to report on the effects of specialty hospital growth, including the advisability of allowing physicians to refer patients to facilities in which they have a financial

stake. How do you feel about the concept of self-referral? What is the status of the HHS study? Do you agree with MedPAC's recommendation that the moratorium be extended until 2007?

Answer:

I understand that there is great interest on the part of the Committee as to the substance of the CMS report, which as you point out, is due to be released early in March, as well as in the recent MedPAC recommendations. I assure you that, if confirmed, I will review this issue and provide a substantive response to your specific question about the Administration's position as soon as possible.

Answers from CMS

To weeks ago, CMS finally gave us answers to questions we submitted to Dr. McClellan during a June 8, 2004 hearing. Why did it take CMS six months to answer these questions?

Answer:

I am not in a position to speak to past practices at CMS. However, I am committed to working with the Congress in a timely and constructive manner, and I will encourage others to do so.

Negotiating Drug Prices

The day Tommy Thompson announced his resignation as Secretary of Health and Human Services, he said he wished Congress had given him "the opportunity to negotiate" with drug manufacturers for lower prices for Medicare beneficiaries. As Secretary of HHS, do you wish to have this opportunity?

Answer:

Competition among private plans to secure favorable drug pricing has been a successful model for other public and private programs, including the Federal Employees Health Benefits Plan (FEHBP). Under FEHBP, the health plans and PBMs that provide coverage for all enrollees, including federal retirees, negotiate prices for their enrollees.

The MMA, as authored by the Finance Committee, as well as alternative proposals introduced by members of both parties, included the provision that prohibits the Department from interfering in the negotiations between private plans and drug manufacturers. The Congressional Budget Office has said that removing this provision from the law would save no money. It is clear that the law intended for seniors to get the best price possible on their prescription drugs, and that is best achieved by having private plans negotiate those prices.

Drug Importation

What do you think about allowing personal and/or commercial importation of drugs from Canada?

Answer:

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to identify actions that will make prescription drugs affordable.

The HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

Some industry officials have said that President Bush sought legislation from Canadian officials to limit drug reimportation to end U.S. debate about the legalization of the practice. What does the administration say in response to this allegation?

Answer:

I am not aware of any such effort. This Administration has worked closely with Congress on a bipartisan basis to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006. HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to identify actions that will make prescription drugs affordable.

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FDA

Do you think the FDA needs to be reformed? When is the President going to nominate someone to be FDA Commissioner? We haven't had a commissioner since March 2004, and before Mark McClellan served as commissioner for a short time, the post was vacant from January 2001 to November 2002. This troubles me. With all these recent announcements that prescription drugs such as Vioxx, Bextra, and Celebrex could be dangerous to your health, I think the American people deserve someone at the FDA other than an "acting director," and the FDA needs to do a better job to ensure our drugs are safe.

Answer:

It is well recognized that FDA's drug review is a gold standard. I believe that FDA maintains the highest standards worldwide for approval and post-marketing monitoring of drugs. FDA has created a strong post-market drug safety program designed to assess adverse events identified after approval when drugs become available to the general public. I know that the FDA is sponsoring an Institute of Medicine (IOM) study on the effectiveness of the United States' drug safety system, with an emphasis on drugs as they are actually used. I look forward to reviewing the results of this study and to working with the FDA and the Congress to further improve the ability of the FDA to monitor and respond to drug safety issues.

Reproductive Services

As a former governor and supporter of state's rights, what is your opinion of the language included in the fiscal 2005 omnibus spending bill last year (Weldon amendment) that prevents states and cities from getting federal funds if they require insurers or medical providers to offer, fund, or refer abortion services?

Answer:

As a former governor, I understand the need for reasonable flexibility in program implementation, whether that flexibility is given to the state or to the service provider. Flexibility should certainly be present when it comes to a matter of whether or not a health care entity can decline to participate in abortion. Respecting the rights of those who decline to participate in abortions is consistent with long-standing Federal policy as reflected in the Hyde Amendment to the annual Labor, Health and Human Services, and Education appropriations bill, the prohibition on abortion coverage under the Federal Employees Health Benefits Program, and the Church Amendment to the Public Health Service Act. This Administration is strongly in favor of protecting the rights of health care entities, including health care professionals, from discrimination because they declined to provide, pay for, or refer for abortions.

To the extent permitted under current federal jurisprudence, many states have in place conditions on the practice of abortion, including conscience protection and non-

discrimination policies for individuals and institutions who do not wish to be involved in abortion. Approximately 46 states have such laws in effect, including Utah. The Weldon amendment is a reasonable and welcome addition to these protections for health care entities.

Interstate Compact for the Placement of Children

As you may know, last year the Administration supported legislation (H.R. 4504) introduced in the House by Rep. Tom DeLay which would have given the Department of Health and Human Services more authority over the interstate placement of foster care children. I have become increasingly concerned with the current status of the Interstate Compact for the Placement of Children (ICPC) and its antiquated rules and regulations. I am interested in knowing your views on this and how you might address this topic if presented to you while at the Department of Health and Human Services.

Answer:

I certainly concur that the Interstate Compact on the Placement of Children (ICPC) needs reform and would support the Administration's efforts to work with Congress on this legislation. While HHS does not have jurisdiction over the ICPC as you noted, the Department is conducting a study on innovative practices in this area. I hope that the information obtained from the study will provide direction on improving services to children who require interstate placement. I look forward to discussing this issue with you further.

I understand that Robin Arnold-Williams, the former Executive Director of Utah's Department of Human Services and an appointee of yours, also serves as the policy council for the American Public Human Services Association (APHSA), and is directly involved in APHSA's rewriting of the Interstate Compact for the Placement of Children (ICPC). I understand APHSA is working on rewriting the compact over the next 4 years. However, I am concerned about the children that are lingering in the system during this time. Do you think Congress should act now and pass legislation to encourage APHSA to make changes or wait until APHSA has rewritten the compact and then determine if federal intervention is warranted? What reforms do you believe should be incorporated into a modernized version of the ICPC?

Answer:

I was well served having Robin Arnold-Williams as the Executive Director of Utah's Department of Human Services. While we are pleased that APSHA is working on the issue, four years does seem too long to wait for reform. I look forward to working with you to implement the reform work that began in the last session of Congress.

Child Welfare

During your tenure as Govenor of Utah, are there any cases involving the ICPC that stand out in your memory that you had to solve or manage? If so, please elaborate.

Answer:

I do not recall any specific cases in Utah involving the ICPC, but as Governor I worked closely with the public and the private sectors to improve child welfare services and will look forward to working with Congress on these issues in the future.

Interstate Compact for the Placement of Children

How do you plan to address ICPC incentives while at HHS? Are there specific reforms you believe Congress should enact now to improve the timely placement of children in interstate cases that are governed by the ICPC?

Answer:

I fully support the Administration efforts to work with Congress on ICPC legislation. In addition, the Department is currently conducting a study on innovative practices in this area. I hope that the information obtained from the study will provide direction on improving services to children who require interstate placement.

Trade Issues

The United States is negotiating a number of trade agreements that include a chapter on intellectual property, which can seriously affect access to affordable medicines as it did with the TRIPS agreement signed in 1994 by extending the patent term of medicines. Given potential international harmonization efforts in this area, that could severely hamper access to affordable drugs, especially within Medicare and Medicaid, shouldn't HHS take a more active role in ensuring that trade policy proffered by the United States Trade Representative (USTR) doesn't adversely affect this country's health care programs and consumers' ability to get affordable medicines?

Answer:

HHS has provided technical assistance to USTR, to ensure that the agreements being negotiated do not conflict with current statutory and regulatory mandates. HHS will continue to work closely with USTR in support of its efforts to ensure that foreign governments recognize the need for incentives for research and development. Doing so benefits patients in the United States, and around the world.

The United States has 5-year data exclusivity periods for new active ingredients. In recent Federal Trade Agreements (FTAs), the USTR has sought the inclusion of

language establishing a period of "at least" 5 years. This means that eventually, with a harmonization process, it could be extended to more than 5 years, thus hurting U.S. consumers and the government (Medicare, Medicare), as it would delay access to more affordable drugs. Are you in agreement with the potential extension of data protection periods? If not, what would you do to prevent this from happening?

Answer:

As far as I am aware, there are no current efforts to increase the 5-year data exclusivity period for new active ingredients (chemical entities). The existing exclusivity was enacted by Congress as a balanced effort between the need to protect pharmaceutical innovation and the desire to bring less expensive generic medicines more quickly to the market.

The Bolar provision is one of the success stories in fostering access to affordable medicines in the United States by allowing the early registration of generic drugs during the term of a patent so that these drugs are available immediately after patent expiration. As Secretary of Health and Human Services, are you prepared to request USTR officials to seek the incorporation of stronger language in trade agreements to ensure that this provision fully incorporates the current U.S. regime?

Answer:

It is my understanding that the agreements permit our trading partners to have regimes comparable to that in the U.S.

A report prepared by the International Trade Commission (ITC) on the U.S.-Australia FTA in May 2004 states that "U.S. industry and government trade officials are especially concerned that the Australian Government may allow domestic drug producers to conduct trials and produce generic equivalents of patented pharmaceuticals prior to the expiration of the patent holders' rights to the legally sold drugs. This would permit domestic producers drugs to obtain Australian regulatory marketing approval in advance of patent expiration so that generic equivalents could be sold immediately once the patents have expired occurred." Do you agree with this position?

Answer:

Existing U.S law permits tentative approval of generic medicines during the innovator's patent term. This tentative approval does not permit marketing in the U..S. and U.S. patent law would prohibit export during the patent term.

A study on drug importation entitled "HHS Task Force on Drug Importation" released last December by the Department of Health and Human Services (HHS) of the U.S. Government states that:

"It is outside the scope of HHS's responsibility, expertise, and jurisdiction to protect intellectual property rights. Issues associated with intellectual property rights should be handled by those with current responsibility to do so".

In light of that statement, how do you perceive so-called linkage provisions that pose such burden on the Food and Drug Administration (FDA)? Let me remind you that this provision has opened the door to a number of abuses unnecessarily delaying access to affordable medicines here in the United States.

Answer:

FDA's responsibility is to implement the generic approval system. This does not permit FDA to approve a generic until patent expiration or, through litigation or otherwise, it is determined that the patent would not be infringed. It is my understanding that the Hatch-Waxman provisions have worked well, allowing for a dramatic increase in the number of generic medicines. While there have some problems with delay in getting certain generics to the market, FDA addressed those problems through rulemaking in 2002 and Congress took further action to prevent unnecessary delay through the Medicare Modernization Act.

Given that the Food and Drug Administration does not have the necessary resources to handle intellectual property matters, would you consider the elimination of the linkage that has led to the improperly listing of patents unnecessarily delaying generic competition? Why is the USTR aggressively pursuing the inclusion of linkage provisions in recent free trade agreements with countries that have far less resources than the United States? Are you in agreement with this policy? What are you prepared to do about it?

Answer:

While there have some problems with delay in getting certain generics to the market, FDA addressed those problems through rulemaking in 2002 and Congress took further action to prevent unnecessary delay in enacting the Medicare Modernization Act. It is my understanding that HHS has provided technical assistance to USTR on the existing U.S. regime for submission of generic applications. The existing agreements are compatible with our current generic approval system and as far as I am aware would permit our trading partners to have comparable regimes.

During the Anthrax scare in 2001, Secretary Thompson used compulsory licenses as a leverage to negotiate with Bayer to lower the price of Cipro. Do you agree with this approach? If so, why is the USTR negotiating free trade agreements that seriously restrict other countries' ability to use compulsory licensing as a tool for negotiating with pharmaceutical companies? Would this restrict the U.S. ability to use compulsory licensing in the future?

Answer:

It is my understanding that Secretary Thompson negotiated with Bayer the per-tablet price at which the federal government would purchase Cipro. His actions were fully consistent with the international agreements to which the US is a party. Secretary Thompson stated, publicly, that if he or the Congress had contemplated breaking the patent, compensation would have to be paid to the patent owner, as required by TRIPS. The TRIPs Agreement contains flexibilities that can be utilized in times of crisis or emergency. These flexibilities are not limited to the United States. They are available to every other member of the WTO.

I support alternative incentives such as BioShield. We need to ensure there is the necessary development of medical countermeasures for injuries and diseases which are the result of terrorist acts.

Do you endorse the Doha Declaration on the TRIPS Agreement and Public Health signed by the United States government in November 2001? If so, what is your position with regards to the TRIPS Plus provisions being sought by the USTR in recent Free Trade Agreements?

Answer:

HHS will continue to provide technical assistance to USTR to ensure the TRIPS Plus provisions are compatible with existing U.S. law and international obligations impacting HHS.

MEDICAID

In your written testimony for the HELP Committee, you indicated that you have followed three goals in public service: First, to leave things better than you found them. Second, to plant seeds for future generations. And, third, to give it all you have. I find the first of those goals particularly important given the ongoing Medicaid debate.

With over 44 million enrollees, the Medicaid program is our nation's largest insurer. It finances nearly 40 percent of all births in the United States. Without it, many pregnant women would forego the prenatal visits and pregnancy-related care that are vital for a child's healthy start. Medicaid provides coverage for one in five of our nation's children, many of whom would otherwise be uninsured. It pays for half of all nursing home care and is the largest single purchaser of long-term care services in the country. In every state throughout our nation, Medicaid keeps hospitals, doctors, nursing homes, and clinics operating in our communities. And, Medicaid does all this at the surprisingly efficient per capita growth rate of 4.5%.

In 2002, you praised a Bush Administration FY 2003 budget proposal that would have offered states 10-year capped allotments for Medicaid. How would a cap on federal Medicaid expenditures in the form of a block-grant make the program better? What would happen to provider payments? How would states respond to growing enrollment in the event of an economic downturn? What would happen to optional populations and benefits?

Wouldn't you agree that there are other ways to give states greater flexibility without capping federal Medicaid spending?

Answer:

There are caps in Medicaid today under 1115 waivers and the successful SCHIP program. I think these are good examples of what states will do with their flexibility. In terms of provider payments and optional populations and benefits, states are cutting them now. We need to give states more tools to react to economic downturns.

There is widespread agreement among Governors that the Medicaid program as described in the statute has not kept pace with the needs of our beneficiaries. The Governors recently wrote to outgoing Secretary Thompson stating among other things, that maintaining the status quo in Medicaid is not acceptable. This consensus is underscored by the high level of interest of Governors in waivers and demonstrations in recent years. The consensus that the current Medicaid statute needs to be revamped is starkly demonstrated through the high degree of interest of among the Governors in securing waivers and demonstrations and making modifications to them (1,078 CMS approvals and actions since January 2001) and the number of states using SCHIP dollars to run non-Medicaid programs or "combination" SCHIP/Medicaid programs (39 of the 56 states and territories). There is widespread consensus that Medicaid is crowding out other important investments, such as education.

The waivers and demonstrations described above allow states to operate their programs more efficiently (such as serving an invidual in the community rather than in a more expensive insititutional setting) and offer optional expansion populations health benefits that more closely approximate what they would receive through employer-sponsored insurance. Since many of these expansion groups are, in fact, working families, that seems like an appropriate use of Medicaid "savings"-- allowing more people access to a benefits package that resembles what they would receive through an employer. It is important when asking about "optional" or "expansion" populations to recognize that these are groups that states are under no federal obligation to cover under the Medicaid statute.

Finally, it's important to realize that Section 1115 demonstrations each come with some kind of spending cap to ensure that the innovations and flexibilities states seek to implement do not cost the federal government more than without the waiver.

Over 2000-2003, 4.8 million people lost their employer coverage. During the same time period, Medicaid enrollment increased by 5.8 million, which kept the number of uninsured in this country at 45 million rather than 50 million. This is exactly how the Medicaid safety net is supposed to work in tough economic times. As employer coverage declines, Medicaid enrollment increases. Now, by all accounts the President is going to propose to drastically cut and/or cap the Medicaid program which completely undermines the safety net. This will undoubtedly exacerbate the problem of the uninsured. Don't you believe that we need to address, not exacerbate, the problem of the uninsured as a country?

Answer:

I agree that the health care safety net is a critical lifeline to some of our most vulnerable populations, including low-income uninsured individuals. What the department has sought to promote -- and will continue to promote-- are ways to give access to health care coverage to those individuals who currently do not have that access.

A number of states have implemented successful public/private partnerships in their Medicaid and SCHIP programs through this Administration's Health Insurance Flexibility and Accountability Initiative. CMS should and does encourage these successful efforts to integrate public and private dollars to make sure the dollars go as far as possible. These states - including Illinois, Maine, Michigan, and Oregon - use Medicaid and/or SCHIP funds to pay insurance premiums for employer sponsored insurance.

So I completely agree that we need to "address, and not exacerbate" the problem of the uninsured. I believe these partnerships – created through the Health Insurance Flexibility and Accountability Initiative – are a step in the right direction.

Under the Utah Medicaid Waiver, which you championed as Governor, very limited coverage was extended to low-income childless adults who did not previously qualify for Medicaid. This expansion population received coverage for primary care services only – no coverage for hospital care (except ER visits), specialty care, or mental health services. In

defending this limited coverage package, Utah indicated that individual in the expansion population would be eligible for charitable care referrals to specialists. However, Utah's own tracking in the first 6 months of eligibility indicates that this did not occur. Of those who were referred to specialists, only a third received service, which means that two-thirds did not.

Given the experience in Utah, aren't you at all concerned about the impact of a "basic" benefits package on beneficiary access to critical medical care? What happens when people need benefits beyond primary care?

Answer:

First and foremost, I believe strongly that waivers provide states with the flexibility to implement innovative ways to extend health coverage to more people. This is a goal we should all support. The waiver that I implemented in Utah did not make any changes to the benefit for mandatory populations. Instead, the waiver expanded preventive and primary care coverage to an additional 25,000 uninsured adults. To do so, a $50 enrollment fee was instituted, but with exemptions for vulnerable optional populations (including the elderly, blind, disabled, children and pregnant women).

States are not required by the Medicaid law to cover optional populations, yet hundreds of thousands of people in this country -- who would otherwise be uninsured -- now have access to healthcare because states have been granted modest flexibility in designing and implementing Medicaid expansions. I simply disagree with the suggestion that the better policy would be to leave all of these people without any health care.

Over 40 percent of Medicaid benefit costs are due to Medicare dual eligibles. States spent nearly $40 billion on dual eligibles in FY2002, sixty-five (65%) of which was on long-term care services. In the absence of a federal long-term care benefit for Medicare beneficiaries, the costs of health care for the dually eligible will continue to rise. This is the true problem with Medicaid. What are your thoughts on how we can improve long-term care financing for Medicaid beneficiaries? What ideas do you have for improving access to long-term care insurance in the general population?

Answer:

Medicaid's eligibility rules and benefit package have an "institutional bias" that favors the institutionalization of individuals needing long term care, rather than supporting their ability to remain in their homes and/or receive services in the community. Thus, states are required to cover services provided in a nursing facility, but must obtain a waiver in order to provide home and community based services. States need flexibility to provide home and community-based services to individuals at risk of institutionalization, before they actually require an institutional level of care, in order to reduce the likelihood of a future need for institutionalization. The Administration believes that the Medicaid long term care system needs to be rebalanced to remove this institutional bias, so that states can meet the needs of Medicaid recipients needing

long term care in the community. This not only will save money, but also will serve the interests of individuals who would prefer to remain in their own homes and communities.

FISCAL RELIEF

For the budget year ending June 30, 2003, Utah reported a budget deficit of $20 million dollars. This was despite the increased cost-sharing and decreased benefits for prior Medicaid enrollees that the state implemented as part of its 1115 waiver one year earlier. Utah's saving grace was the federal fiscal relief enacted in 2003, which allowed the state to finish the budget year with an $18 million surplus.

Because block-grants do not keep pace with inflation or adequately respond to increases in Medicaid eligibility, wouldn't such a financing structure make it more likely that states will come to the federal government more frequently for fiscal relief to help cover unforeseen health care costs?

Answer:

Again, I think it bears pointing out that caps have been a part of our program's financing structure for a very long time. Also, as long as a cap is calculated to take into account reasonable growth in caseload and medical inflation, there is nothing inherently wrong with a budget ceiling per se. As I have mentioned most--states have waivers and/or demonstrations that operate with caps. And there are sound reasons, reasons beneficial to the state, for them to do so.

MEDICARE

The transition of 6.4 million dual eligibles from Medicaid prescription drug coverage to Medicare Part D will be a big challenge for HHS. First, there is the technical challenge of transferring information on the duals from state databases to HHS. Second, there is the education and outreach challenge of making sure that all duals know they have new drug coverage and, possibly, new providers. And, finally, there is the challenge of making sure that beneficiaries receive access to all the drugs they need, even when those drugs are not covered by their Part D prescription drug plans. What steps is HHS taking to ensure a seamless transition of the duals from Medicaid to the new Medicare Part D drug benefit? How will CMS ensure continuity of care for patients who are currently receiving psychiatric medications? How will CMS ensure that prescription drug plans' formularies reflect best evidence regarding unique therapeutic agents? Has HHS given any consideration to MedPac's June 2004 finding that six months are necessary in order to have a "smooth" transition from one insurance program to the next?

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I

agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

CMS is working to assure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any particular types of beneficiaries. CMS intends to encourage and approve formularies that provide the types of drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories and classes and the formulary list offered are not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building formularies and structuring their bids. CMS will expect plans to recognize the special needs of the mental health patients.

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries.

Plans must use a pharmacy and therapeutic committee including practicing doctors and pharmacists to establish a formulary, so plan enrollees can be assured that they have access to the most effective, up-to-date drugs possible. Plans have the option of using the recently completed model guidelines from US Pharmacopoeia as their formulary classification system or developing their own, but in either case CMS will review the drug chosen to make sure that the formulary is adequate and does not discriminate against certain groups of beneficiaries.

Finally, CMS and the states will provide educational and outreach materials to inform dual eligible beneficiaries of their options under Part D and to assist them in their decision-making processes.

It is important to note that private health plans have little experience with the mentally ill population, since these individuals are often considered disabled and therefore covered under State Medicaid programs. As such, drug plan applicants will need significant technical assistance to adequately address the needs of the mentally ill population (who are dually eligible for Medicare and Medicaid based on their disability status). A number of agencies within the federal government have medical, clinical and scientific expertise that is directly relevant, including the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health. What role do you envision for these agencies to work in collaboration with CMS to provide expertise?

Answer:

CMS expects that treatment guidelines from these agencies and other respected sources will be an input into plan Pharmacy and Therapeutic committee decision making around issues related to mental health. CMS will check plan formularies to ensure that they support treatment guidelines

for a range of diseases, including some mental illnesses. CMS can work with these agencies to provide any additional expertise that plans need in dealing with mental health issues.

At yesterday's hearing before the HELP committee, it was asserted that much of the $139 billion difference between the CBO and the CMS Office of the Actuary's cost estimates for the Medicare law is due to the employer subsidy. In fact, the CMS Office of the Actuary (OACT) has indicated that the difference in cost estimates is due largely to higher enrollment estimates ($32 billion), higher estimates for the number of beneficiaries eligible for the low income subsidy ($47 billion), fewer savings to Medicaid ($18 billion), payments to Medicare Advantage Plans ($32 billion), and technical assumption differences ($10 billion). In enacting the Medicare law, Congress agreed on the need to protect retiree health benefits and therefore provided a subsidy to encourage employers to continue that coverage. While the Medicare law does not go as far as I would like to encourage employers to retain retiree coverage, the employer subsidy represents clear Congressional intent to protect retirees. I certainly hope the Administration will maximize that incentive in the Medicare regulations which will soon be released. Don't you agree that it is important to protect employer-provided retiree health benefits?

Answer:

It's important that employer provided health benefits are protected. CMS has previously put forth several policy goals in this area:

- Maximize the number of retirees with employer-provided retiree drug coverage, and maximize the generosity of their coverage;
- Preclude "windfalls" (by assuring that plan sponsors contribute to retiree drug coverage at least as much as Medicare pays them as a subsidy);
- Minimize administrative burden while maximizing flexibility for employers and unions; and,
- Limit overall budgetary costs.

In enacting the Medicare law, Congress provided for a subsidy for employers that retain retiree health benefits that are at least equal to the Medicare Part D benefit. Within that statute, the Administration has broad authority to implement the employer subsidy, particularly in the way in which the test for "actuarial equivalence" is defined and applied. The Administration must also ensure that this new subsidy is in fact used for its intended purpose: to preserve retiree health benefits. What assurances can you give to demonstrate the Administration's commitment to ensuring the subsidy is used to preserve retiree health benefits that are at least as generous as the Medicare Part D benefit?

Answer:

It's important that employer provided health benefits are protected. CMS has previously put forth several policy goals in this area:

- Maximize the number of retirees with employer-provided retiree drug coverage, and maximize the generosity of their coverage;

- Preclude "windfalls" (by assuring that plan sponsors contribute to retiree drug coverage at least as much as Medicare pays them as a subsidy);
- Minimize administrative burden while maximizing flexibility for employers and unions; and,
- Limit overall budgetary costs.

CHIP

Last year, Senators Chafee, Kennedy, Snowe and I authored comprehensive legislation to shore up CHIP financing through fiscal year 2007. This legislation, known as the Children's Health Protection and Improvement Act, would have extended the availability of $1.07 billion in expiring CHIP funds so that West Virginia and other higher-spending states could use those funds to expand coverage to additional children. Despite the support of 37 Senators and 82 Members in the House, the Administration opposed this approach, and instead offered early CHIP reauthorization as a solution.

Administrator Leavitt, can you shed some light on the policy rationale for early CHIP reauthorization? What do you think is the likelihood for success, given how difficult it has been to reauthorize TANF since it expired in 2002 and how difficult it was for Congress and the White House to reach consensus on a comprehensive CHIP policy last year?

Answer:

The President stated this past summer that he would like to significantly improve outreach in an effort to enroll the remaining eligible but as yet uninsured children. I look forward to working with Congress towards the goal of covering more kids.

TRADE ADJUSTMENT ASSISTANCE

The Trade Adjustment Assistance Reform Act of 2002 (TAARA) offered trade displaced workers and retirees a tax credit toward the purchase of health insurance coverage. The tax credit is for 65% of the cost of health insurance. The Internal Revenue Service at the Treasury Department implements the tax code provisions, the Department of Labor grants TAARA petitions, and the Department of Health and Human Services certifies the qualified health plans.

The number of people who have been able to access the health care tax credit over the last two years is extremely disappointing. As of July 2004, only 13,194 out of 229,044 who are eligible for the credit are enrolled in the program. That is less than six percent, which means that over 94 percent of those eligible are not participating. What do you think can be done to improve enrollment in the program?

Answer:

Because this program is administered by the Internal Revenue Service, I would defer a specific answer on how to improve enrollment in the program to the Treasury Department. However, we should keep in mind that while participation may be lower than anticipated, it is quite similar to the SCHIP program which, in its first full year (1998), had an enrollment of less than 10%. But in most states, SCHIP was built on an existing administrative structure (i.e., Medicaid programs) and dealt with a population that was largely familiar with the insurance and the administrative process because of Medicaid.

MEDICAL MALPRACTICE

Mr. Leavitt, West Virginia doctors have seen their malpractice insurance premiums rise dramatically over the last few years. Prompted by a doctor walk-out in protest of high premiums, and the threats of additional work stoppages as well as the specter of doctors permanently leaving West Virginia, our former Governor, Bob Wise, worked with our state legislature to pass medical malpractice reform legislation in 2003. Among other provisions, the law capped victims' damages. I would note that, as the insurance industry experts candidly admitted when the issue was before a state legislature committee, premiums have not gone down despite victims' rights to collect damages being curtailed.

Now, both tort and insurance law are traditionally the province of state legislatures. The federal government has generally stayed out of those areas. This is the essence of federalism. Nevertheless, the President has seized on the undeniably high premiums being paid by doctors, and has decided this "crisis" demands federal action. One might conclude that any such action would necessarily include some regulation of the insurance industry. Instead, the President seeks to limit what a patient can collect for injuries by what a jury determines to be malpractice.

Please help the Committee understand how you would counsel the President on this, and share your thoughts with us on the following related questions:

a) **Would you agree with the President that an understandable concern for doctors facing crippling premium increases justifies a policy choice that cannot but harm injured patients, especially children and stay-at-home moms?**

Answer:

The policy that the President is advocating will help all patients by increasing access to care. It will stabilize the price and availability of insurance and thus avoid the situation that is currently causing many doctors to leave practice prematurely, to restrict their practice, or to leave states that have not reformed their tort system to go to states that have.

b) **Would you suggest to the President that any meaningful reforms designed to bring down the cost of medical malpractice premiums must, by definition, include regulation of the insurance industry and its premium-setting function? If not, are**

you prepared to defend a decision by the Administration to stigmatize the victims of malpractice while turning a blind eye toward the profits – and past investment errors - of the insurance industry?

Answer:

The insurance business is currently regulated by the states. These regulations include restrictions on the types of investments that insurance companies can make. I do not believe that the reforms of the litigation system that the President would provide a reason to introduce Federal regulation of insurance.

c) **The number seemingly enshrined in the debate – a cap on non-economic damages of $250,000 - was first proposed by the California legislature in 1975. Do you believe, as the President apparently does, that $250,000 is some sort of magic number that cannot be deviated from? Perhaps a child – with no lost wages to collect - who suffered serious injuries with lifetime implications due to a doctor's negligence in 1975 could be taken care of for the rest of his or her life on $250,000, but, as the President's nominee to head the Department of Health and Human Services, with access to projected future costs for care and rehabilitation, would you have the Committee believe that $250,000 is adequate in 2005?**

Answer:

The President's proposal would not limit economic damages, which includes the amount the child could recover under state law for care and rehabilitation.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

As a former Governor, I trust that you share some of my concerns about the importance of state flexibility with the Temporary Assistance for Needy Families. For example, I believe that West Virginia and Utah, like many rural states face huge transportation challenges. It can be difficult for a parent to make a successful transition from welfare to work without a reliable means of transportation. How can we work together to enhance options for investments in transportation?

Answer:

State flexibility is a very important part of America's success with welfare reform and I have been a strong advocate for flexibility as Governor of Utah as you note. In Utah we worked hard to help families facing many types of challenges transition from welfare to work, and transportation is certainly a critical element for many families. TANF offers a great deal of flexibility to address these challenges and I look forward to hearing your thoughts and working with you on this issue.

As a block grant, TANF funding has not increased since 1996 and inflation has. This has reduced the value of the TANF block grant by more than 16%. How can states cope for less funding given all the other financial pressures they face?

Answer:

Answer: Since enactment of the TANF program, the approach States have taken in working with families has changed substantially and that has had very positive effects, by increasing employment, reducing poverty and ultimately resulting in welfare caseloads now less than half what they were when TANF was created. TANF programs are now better oriented toward helping families than in 1996, and there are far fewer families requiring assistance. However, more can be done to improve the TANF program, and I look forward to working with you and other members of the Committee on the critically important reauthorization of the TANF program.

Child care is an obvious priority and compelling needs as parents make the transition from welfare to work, and child care during non-traditional hours – weekends and evenings – is usually more expensive. How can the Administration justify increasing the hours of work and activities for parents without providing the necessary child care funding?

Answer:

The historic reductions in welfare caseloads and child poverty since TANF's creation have given states a far greater ability to address child care challenges than they had in 1996. By reducing welfare dependency states have been able to dedicate far more of their TANF funds toward child care than in the past. TANF's flexibility and focus on work has improved our ability to help families become stronger and more self-sufficient. The President's proposed legislative reforms will help States run their programs even more effectively. I look forward to working with you and other members of the Committee on reauthorization of the TANF program.

During the last recession, the TANF contingency fund failed to offer relief to states that were clearly struggling. Do you agree that we need a more effective contingency fund during recession for the states, and are you willing to discuss streamlining the administrative burden by eliminating the additional maintenance of effort (MOE) requirement for states to tap the contingency fund and having a single MOE requirement for all provisions of TANF and flexible standards for states to trigger onto contingency funding?

Answer:

The President's reauthorization proposal for the TANF program contains several revisions to ease administration of the contingency fund. I would be pleased to work with you on this issue as we focus our efforts on reauthorization of the TANF program.

CHILD WELFARE POLICY

I am pleased to note that as Governor of Utah, you made substantial investments in staff for child welfare cases, and saw the gains of such investments. How can we work together to promote key investments in staff for child welfare policy?

Answer:

I am extremely proud of the work we did in Utah to strengthen our child welfare program and appreciate your interest in continuing to focus attention on this very important issue. You have been a strong advocate of sound child welfare policy for many years and much has been accomplished to strengthen child welfare programs. As you note, however, more needs to be done to improve these critical services for this vulnerable population.

I am a strong proponent of maximum State flexibility and believe the President's Child Welfare Program Option would address your concern about promoting staff development and many other issues currently faced by States in managing their child welfare programs. States that opt to participate in the Child Welfare Program Option would benefit from unprecedented flexibility in the use of title IV-E funds. These states would have the flexibility to use title IV-E dollars to create a seamless continuum of care in child welfare. The funds may be used for a host of activities from prevention to creating alternative permanency arrangements such as subsidized guardianship to addressing the staffing issues you identified in your question. I look forward to working with you on this key legislative initiative to support innovation and strengthen child welfare programs across the country.

I believe it is unfair to base a child's eligibility for adoption assistance based on the income of the abusive parent whose parental rights are being terminated. I have a bipartisan bill, known as the Adoption Equality Act to ensure that every special needs child can receive adoption assistance, and fund this proposal rather than passing the bill onto struggling states. I would like your careful review and comments on this legislation.

Answer:

I appreciate your interest in focusing on the complex questions associated with eligibility criteria for the Federal Adoption Assistance program. The President's Child Welfare Program Option legislation does address some of the eligibility issues related to the Adoption Assistance program. I would be pleased to discuss those provisions with you as well as review any legislation you develop to simplify the Federal adoption program.

During the last Congress, I introduced legislation to collect state-by-state data on child well-being, known as the State Child Well-Being Act, and I intend to re-introduce similar legislation. As states have diversified and used their flexibility under TANF and other social service programs, I believe it is critical to have information on individual states, especially rural states like West Virginia.

Answer:

I appreciate your interest in obtaining more comprehensive data related to child well being and would be pleased to review any legislation you introduce.

ENVIRONMENTAL PROTECTION AGENCY

Mr. Leavitt, I am concerned that your record with regard to the environment and its potential effects on human health is not in keeping with the position of Secretary of Health and Human Services.

As Governor of Utah, your record shows you routinely sided with industry in regulatory matters. This record includes a proposal to end all environmental regulation of the hardrock mining industry wastes, despite uncontested scientific evidence that the waste contains toxic chemicals, including the neurotoxin mercury. I believe you were quoted as believing that hardrock mining waste was "in reality...not pollution."

Under the "market-based" regulatory regimen of your tenure as Governor, Utah had the second-highest volume of industrial toxics in its air and water, and the overall water quality dropped into a tie for last among all states.

Can you explain to the Committee how your casual view toward environmental regulation and the very real potential for corresponding adverse effects to human health prepares you to be in charge of a Department responsible for the health of Americans?

Answer:

My record of accomplishments in safeguarding the environment and protecting human health are well documented (see summary below). Air and water quality improved, as well as key health indicators.

Hard rock mining in Utah is regulated to protect public health and the environment. Under my leadership, and continuing today, Utah regulates mining operations and has safeguards to ensure that Utah's groundwater is protected. Mining companies in Utah comply with the reporting requirements of the Toxic Release Inventory.

With regard to air quality, the air became demonstrably cleaner during my administration. My support for enhanced vehicle emissions testing, modernization of Utah's transportation system – including an aggressive expansion of public transportation, and enhanced civic engagement through Envision Utah, a quality growth partnership, helped move Utah into attainment with federal air quality standards.

Utah's water quality also improved during my service and is among the nation's cleanest. When I completed my service as Governor, 73% of Utah's streams met federal water quality standards, compared to 59% ten years ago, a 24% improvement since I took office. There has been some confusion about Utah's water quality record because of some reporting errors that were

incorporated into a U.S. PIRG report. Once the data was corrected, Utah's compliance rates were among the ten best in the nation.

In the health arena, Utah's immunization rate climbed from 43.7% in 1995 to 78.8% in 2003; teen smoking rates dropped from 17.4% in 1993 to 7.3% in 2003; and, infant mortality rates declined from 5.8% when I took office to 5.0% when I departed. In addition, over 400,000 more people in Utah have health insurance than they did in 1993 when I began serving as Governor of the state.

Leavitt Confirmation
Santorum Questions for the Record

In 2002, the Congress passed and the President signed into law the Born Alive Infants Protection Act. This law states that an infant, who is born alive at any stage of development, is considered a person under federal law and regulation. This was intended to protect the most vulnerable infants in our society and to ensure appropriate care is provided for those infants who survive an abortion. I am aware of reports that hospitals are continuing to perform induced labor abortions, yet may not be providing the appropriate level of care to infants who survive the abortion and are born alive. How will you use the resources of HHS to make hospitals aware that infants, who are born alive, even if during an abortion procedure, are considered persons under the law and should be cared for under the appropriate standard of medical care? Is there any plan to issue HHS guidelines or regulations to ensure that hospitals comply with this law?

Answer:

The Administration strongly supported enactment of the Born Alive Infants Protection Act to guarantee an infant's legal protection, whether the infant's delivery was natural or the result of an abortion. It would be a matter of great concern to me if hospitals are not fully aware of, or are disregarding, federal legislation and protections for newborn children or are not providing appropriate medical care to these infants. I would be very interested in discussing this issue with you further and receiving the information that raised the problem to your attention once again.

A large percentage of Title X family planning funding goes to Planned Parenthood entities, many of which provide abortions in the very facilities that also receive federal funding. Do you believe that Title X funding should continue to subsidize clinics also providing abortions?

Answer:

Any public or nonprofit private entity in a State is eligible to participate as a grantee in the Title X programs authorized under section 1001 of the Public Health Service Act. Services are delivered through a network of community-based clinics that include State and local health departments, hospitals, university health centers, Planned Parenthood affiliates, independent clinics, and public and nonprofit agencies. Of the 86 family planning service delivery grant projects funded in fiscal year (FY) 2004, 9 were grants to Planned Parenthood organizations. Other Planned Parenthood organizations serve as delegates of State health departments.

Section 1008 of the family planning statute explicitly states that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." Annually, as part of the grant application submission, grantees sign an assurance that they will not violate section 1008. Any non-Title X abortion activities must be separate and distinct from Title X projects. A grantee must demonstrate that prohibited abortion-related activities are not part of the Title X project by various means, including an examination of its counseling and service protocols, intake and referral procedures, review of clients education materials, financial records and other administrative procedures.
The issue of collocated abortion and Title X clinics is a very serious issue. The Title X statute is clear that Title X may not be used to subsidize abortion.

In addition, Planned Parenthood continues to be blatantly political and partisan in its rhetoric and actions. While appropriations riders have prohibited them from using federal funds for such activities, I question whether federally-funded entities should act in this way. How does HHS use its oversight of Title X grantees to ensure that federal funding is not used for political activities?

Answer:

All notices of grant award (NGAs) include a condition of grant award stipulating that grantees must comply with the restrictions on lobbying set out in Federal regulations at 45 CFR Part 93. In addition, all NGAs also require that grantees comply with the restrictions on grantee lobbying contained in the annual appropriations bill. There is no official HHS monitoring tool to determine whether Title X funding is being used for political purposes. However, given the importance of accounting for taxpayer dollars I agree that this is something that we need to assure in an appropriate oversight mechanism for all grantees receiving Federal funds.

The family planning program utilizes several mechanisms to oversee grantee compliance with program requirements, as well as other relevant Federal requirements such as restrictions on lobbying. Further, individual grantees are required to monitor service delivery organizations with which they have sub-contract agreements. Individual family planning programs undergo comprehensive program review every three years. These reviews cover financial, administrative, counseling and clinical issues. In addition, programs are evaluated when they apply competitively for refunding, every three to five years. Regional offices also make annual site visits to grantees. The site visits and program reviews provide observational assurance that grantees are complying with Title X and other Federal financial, administrative, counseling and clinical requirements.

Congressional Budget Office Director Holtz-Eakin stated in a January 23, 2004 letter to Majority Leader Bill Frist that removing the non-interference provision of MMA would have a negligible effect on federal spending for prescription drugs. This analysis showed that giving the government the power to negotiate directly with pharmaceutical manufacturers would produce no additional savings. Given CBO's strong stance on this issue, do you see any reason to change or revisit the non-interference provision in the law?

Answer:

The MMA, as authored by the Finance Committee, as well as alternative proposals introduced by members of both parties, included the provision that prohibits the Department from interfering in the negotiations between private plans and drug manufacturers. The Congressional Budget Office has said that removing this provision from the law would save no money. It is clear that the law intended for seniors to get the best price possible on their prescription drugs, and that is best achieved by having private plans negotiate those prices.

In MMA, Congress requires that Medicare prescription drug plan formularies cover at least two drugs in each drug class. Commercial formularies, such as those used by the Federal Employee Health Benefits Plan, typically provide more drug choices. What will

you and CMS do to provide seniors and the disabled with a comparable choice of drugs? How will beneficiaries who enroll in Part D coverage be assured access to a range of drugs that is sufficient for all of their needs?

Answer:

CMS's review of the drug plans formularies' will begin by looking at the categories and classes of covered drugs. Even more important are the drugs that are included on the list and what co-pay tiers those drugs are assigned to. This will involve more than simply assuring that the plan covers at least two drugs per therapeutic category. CMS intends to have a vigorous review process with numerous checks to make sure that a sufficient range of drugs is available to all Medicare beneficiaries and that vulnerable groups are not discriminated against in drug selection or through co-pays.

Per a requirement in the MMA, CMS requested the U.S. Pharmacopeia (USP) to develop a model set of guidelines consisting of a list of drug categories and classes that may be used by plans to develop formularies for their Part D coverage, including their therapeutic categories and classes. The USP listing will simply serve as a model set of guidelines, however. Plans will have the flexibility to develop their own formulary classification schemes. However, to the extent that a PDP sponsor or MA organization offering an MA-PD plan designs its formulary using therapeutic classes and categories that vary from the USP classification model, CMS will evaluate the submitted formulary design to ensure that it does not substantially discourage enrollment by certain Part D eligible individuals.

In 2006 over 6 million low-income Medicare beneficiaries who qualify for full benefits under Medicaid, also known as "dual eligibles," will begin to receive prescription drug benefits through Medicare. Given that this is an especially vulnerable population, what steps will HHS take to ensure that these beneficiaries will have a seamless transition to the new Medicare drug benefit?

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts.

CMS is working to assure that drug plans provide access to medically necessary treatments for all beneficiaries and do not discriminate against any particular types of beneficiaries. CMS intends to encourage and approve formularies that provide the types of drug lists and benefit management approaches that are already in widespread use. In addition to determining that the categories and classes and the formulary list offered are not discriminatory, CMS intends to check the plan design, using clear benchmarks that plans can utilize as a guide in building

formularies and structuring their bids. CMS will expect plans to recognize the special needs of the mental health patients.

Finally, CMS and the states will provide educational and outreach materials to inform dual eligible beneficiaries of their options under Part D and to assist them in their decision-making processes.

In the December 21, 2004 Surgeon General Report on Prescription Drug Importation, "There is no realistic level of resources that could ensure that personally imported drugs are adequately inspected to assure their safety since visual inspection, testing and oversight of all personally imported prescription drugs are not feasible or practical at this time." Considering the difficultly in ensuring the safety of imported prescription medicines, how could such a system operate without putting the health and lives of American's in danger?

Answer:

The HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to work to make high-quality prescription drugs more affordable and available for all Americans.

Some in Congress have suggested that in order to lower drug costs in this country, we should import drugs from price-controlled countries, such as Canada. However, according to the December 21, 2004 Surgeon General Report on Prescription Drug Importation, "Total savings to drug buyers from legalized commercial importation would be one to two percent of total drug spending". How are Americans going to benefit from imported medicines when savings are so limited and safety cannot be assured?

Answer:

The HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and

identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

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In October 2004, CDC was abruptly notified by Chiron Corporation that none of its influenza vaccine would be available for distribution in the United States for the 2004–05 influenza season. This action reduced by approximately one half the expected supply of the flu shot available in the United States for the 2004–05 influenza season. This incident highlighted the importance of domestic production and the need for maintaining supply options as defenses to another flu shot shortage. Are you committed to working with the vaccine industry to maintain and grow domestic flu shot production, as one way to prevent another flu shot shortage? This year there is a $100 million appropriation for strengthening our domestic flu production. Are you willing to work with industry and Congress to use that money in effective, creative ways?

Answer:

Preparation for the annual flu season has been a priority at HHS. I will ensure that it continues to be a priority. I believe that the CDC and FDA have successfully taken great strides towards responding to an unforeseeable shortage of vaccine, through the creation of tools to help States identify additional vaccine, through the identification and purchase of additional vaccine under an investigational new drug (IND) application, and through effective public communication about the prioritization of high-risk groups who should receive the available vaccine.

I will also ensure that efforts to prepare against a possible influenza pandemic continue to be a priority, including through the continued review and finalization of the national pandemic response plan, as well as through the utilization of the $100 million recently allocated to these efforts in the Omnibus appropriations bill.

Looking forward to the future, we will continue to work with vaccine manufacturers to encourage them to bring their vaccine for licensure and sale in the U.S., as well as taking longer-range steps to encourage the development of a domestic vaccine supply, to ensure appropriate supplies of influenza vaccine. I look forward to working with the Committee on this issue - any

steps that we take should be careful to remove disincentives that may have hindered manufacturers from entering or remaining in the U.S. vaccine market.

Medicare established the first prospective payment system (PPS) in the ESRD Program in the early 1980s. Since that time, we have learned a great deal about how the PPS methodology works. Yet, the ESRD program remains the only program that does not receive an annual update. For 2005, MedPAC has calculated a projected margin on dialysis services of –0.03 percent when combining the composite rate and injectible drugs. How will HHS work to ensure the economic stability of this important sector of the health care community?

Answer:

While the ESRD composite rate payment methodology is similar to a PPS, about 35 percent of ESRD facility payments are made outside the composite rate methodology. Separately billable labs and injectable drugs are paid based on fee schedules which are updated at least annually. CMS does not have the statutory authority to update the composite rate payment amounts. The MMA provided for a 1.6% increase for 2005, and also provides for a 1.6% update in 2006 for facilities participating in bundled payment demonstration that is scheduled to begin January 1, 2006.

Provisions of the MMA (sec. 623) ask CMS to do two things that are relevant to the development of future ESRD payments under a fully bundled (Composite rate and drugs) PPS: (1) a report to Congress that includes a discussion of how to update payments under such a PPS; and (2) a demonstration of a fully bundled PPS. The Department is currently working to advance these projects.

Abstinence education provides teens with the important message that abstinence is the only 100 percent effective way to prevent teen pregnancy and STDs. Over the last four years, President Bush has consistently indicated his desire to increase abstinence education funding, last year requesting that the funding level be increased to $270 million. Do you share the President's commitment to abstinence education? How will you work to ensure that this priority is reflected in the policies of HHS?

Answer:

I appreciate your interest in the abstinence education program and share the view expressed by you and the President that "Abstinence is the surest way and the only completely effective way to prevent unwanted pregnancies and sexually transmitted diseases." I am committed to vigorously supporting efforts to obtain adequate funding for abstinence education programs so that we can provide effective programs and accurate information to our nation's youth. I look forward to working with you to help our nation's youth make the best choices for themselves.

As Secretary, what steps would you take to further the important objective of increasing opportunities for smaller faith-based and community based organizations to be full partners in addressing the social and poverty challenges facing our country?

Answer:

The Faith-based and Community Initiative championed by President Bush made great strides over the past four years in leveling the playing field for these types of organizations to receive Federal funding. I am aware of several key programs in my Department that specifically target funding to faith-based and community-based organizations, including the Compassion Capital Fund which was designed to help small faith-based and community organizations compete for Federal funding by providing expert advice in grant writing, capacity building and service delivery. HHS also initiated the President's Mentoring Children of Prisoners program calling on the compassion of all Americans to become a positive presence in the lives of these children. I look forward to building on these successes and exploring more ways to help faith-based and community organizations provide the grass roots services and support to those in need.

Leavitt Confirmation
Schumer Questions for the Record

In testimony before the Finance Committee in 1997, you joined a group of governors in "adamantly"opposing a cap on Medicaid spending in any form, saying that "[a]ny unilateral cap on the Medicaid program will shift costs to state and local governments they simply cannot afford," and that such proposals would "help the federal government balance the budget on the backs of the states." However, in 2002, you praised the Administration's FY03 budget proposal to cap Medicaid allotments. As Secretary, will you preserve the current federal commitment to the Medicaid program and oppose further shifting the cost burden to states, or will you push to block-grant the program and cap federal funding?

Answer:

The Administration has not proposed to block grant the Medicaid program. It is committed to maintaining the entitlement of mandatory populations to mandatory services. At the same time, I believe that States cans be given more flexibility to extend health insurance coverage to more low-income individuals and families.

Since I was elected to the Senate, I have made it a priority to address the skyrocketing costs of prescription drugs. Primarily, I have focused on ensuring that consumers, corporations, state governments and others have access to low-cost generic drugs. The Medicare Modernization Act included a pro-consumer piece of legislation I authored with Senators Judd Gregg, Edward Kennedy and John McCain to curb drug patent abuses by the brand industry to ensure timely access to generics. But now, new practices by the drug industry and other legislative proposals threaten to reverse the effects of these provisions and further undermine access to lower cost prescription drugs – which could cost consumers, state governments, and now the Medicare program literally billions of dollars in unnecessary drug costs. In addition to the specific questions below, what steps do you plan to take to lower drug costs for consumers and purchasers of prescription drugs?

Answer:

I believe it is critical that we improve Americans' access to high-quality, affordable prescription drugs, and I intend to make this a priority, most notably through continued implementation of the Medicare Modernization Act, as well as through improved public awareness of the benefits of high-quality generic drugs. We should continue to provide funding at the FDA to ensure the safe and timely review of high-quality generic drug competition, as well as to take additional steps encouraging the use of lower-cost generic alternatives, where medically appropriate.

Current statute allows for commercial reimportation of prescription drugs from Canada as long as the Secretary of HHS certifies that it can be done safely and save money. The Administration has expressed many concerns about the safety of reimportation – concerns which I and many of my colleagues do not feel are warranted, as many of the drugs we're

talking about are produced right here in the United States. However, the report released in December by the HHS Task Force on Drug Importation seemed to leave open the possibility of safe commercial importation from Canada. Will you exercise the power Congress has granted the HHS Secretary to help American consumers and the Medicare and Medicaid programs save millions by opening our borders for safe reimportation?

Answer:

This Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has also worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to identify actions that will make prescription drugs affordable.

The HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

In a letter to Secretary Thompson dated November 30, 2004, Senators John McCain, Jay Rockefeller and Arlen Specter joined me expressing our concerns about a new abuse by the drug companies which undercuts the incentives for generics to challenge weak patents and get to market as quickly as possible. Specifically, while Hatch-Waxman grants a 180-day exclusive marketing right to the first generic to challenge weak brand patents, brand companies are significantly undermining this incentive by licensing their drugs to other generic companies and coming onto the market just before and during this 180-day period.

Not only does this practice undermine key incentives in the Hatch-Waxman Act, but HHS has been inconsistent in its treatment of such "authorized generics," to the benefit of brand drug companies and the detriment of consumers and payers. Specifically, the FDA allows the practice because they consider the drug to be the *same* as the brand drug, while CMS considers the drug to be *different* from the brand drug, and thus does not require the brand company to report the price of the authorized generic in its "best price" reporting for the purpose of Medicaid reimbursements – a practice which could be costing Medicaid

millions. How do you plan to address this inconsistency in policy to ensure that Hatch-Waxman incentives are preserved and low-cost generics come to the market as quickly as possible?

Answer:

I believe it is critical that we improve Americans' access to high-quality, affordable prescription drugs, and I intend to make this a priority, most notably through continued implementation of the Medicare Modernization Act, as well as through improved public awareness of the benefits of high-quality generic drugs.

You raise an important question relating to the use of "authorized generics" in our efforts to make prescription drugs more affordable for all Americans. In response to concerns that the marketing of "authorized generics" undermines the incentive to for generic drug competition created in the Hatch-Waxman Amendments, FDA has reviewed its legal authority to limit such marketing practices. The Agency has concluded that it does not have the authority under the Federal Food, Drug, and Cosmetic Act to prohibit the marketing of an "authorized generic" that was manufactured pursuant to the innovator's approved new drug application. FDA's position on its scope of authority has been affirmed in a recent U.S. District Court decision. For purposes of the Medicaid drug rebate program, CMS has determined that authorized generic drugs should be treated as innovator drugs if the authorized generic is being marketed pursuant to the brand manufacturer's new drug application.

One of my priorities will be to continue the great progress made by this Administration in expanding the availability of high-quality, affordable prescription drugs. You raise important questions, and I hope to work with you on these issues as we move forward.

In October, the Judiciary Committee held a hearing to discuss legislation to expand incentives for drug companies to develop life-saving countermeasures to be used in the event of biological, chemical, and nuclear attacks. One proposal discussed at the hearing would have awarded a drug company with a two-year "wildcard" patent exclusivity to be added to any drug the company sells, in return for conducting studies on a potential countermeasure. This reward – worth $12-14 billion on the biggest blockbusters – would be granted regardless of whether the company actually *produced* the countermeasure. This provision, and others in the proposal, would lead to huge delays in consumer access to generic drugs. Do you support such an approach which would cost consumers and the Medicare and Medicaid programs billions of dollars with no guaranteed return?

Answer:

One of the highest priorities of the Department of Health and Human Services is to ensure the availability of medical countermeasure to protect the American people in the event of a terrorist attack. I believe that Project BioShield has helped encourage development of needed

countermeasures and improve our ability to move rapidly to acquire those countermeasures for the national stockpile. This is a critical effort, and I look forward to working with Congress as we continue to implement this program to identify any possible ways we can better meet this goal. As you know, Congress has acted previously by providing incentives for the development of products that could possibly save millions of lives. A similar approach to the proposed awarding of additional exclusivity for performing studies, implemented under the pediatric exclusivity provision of the 1997 FDA Modernization Act, has benefited many children. However, I am not today able to comment on any specific proposals, and I would hope to work with Congress to carefully weigh the various alternatives in this area.

Currently there is not a dedicated pathway in the Food, Drug & Cosmetic Act or the Public Health Service Act for the approval of generic versions of biologic medicines. However, many in the drug industry argue that both the science and the statutory authority exist to allow the FDA to approve lower-cost, "follow-on" versions of certain biologic drugs. The FDA conducted a symposium in September to hear the brand and generic industries' perspectives, but the Agency has yet to opine on either the science or statutory authority, and plans to convene yet another symposium in February. Biologic drugs are some of the most expensive on the market. With billions of dollars at stake on life-saving medicines, do you support a more aggressive approach by the FDA to take action to approve follow-on biologics where the science exists to do so?

Answer:

Follow-on proteins offer the potential for lowering the cost of certain drugs, but there are many scientific, legal, and policy questions that must be answered regarding these products. Currently, FDA is conducting a public process to examine these issues. I support this process because it will ensure that FDA's approval authority is fully examined and that all interested parties have an opportunity to comment. When this process is complete, FDA intends to provide guidance to industry to clarify, consistent with its legal authority, the approval pathway and principles for review of such products, which will protect the public health.

As you know, starting with the Balanced Budget Act of 1997, Congress slashed Medicare funding for hospitals, reducing funding for NYC teaching hospitals alone by over $1 billion to date. The latest cut, in 2002, reduced funding for teaching hospitals in the state by $140 million annually. While we restored some of that in the Medicare bill, the relief was paltry compared to the size of the cut. On top of that, the Administration's decision to add three New Jersey counties to the New York City metropolitan statistical area will cost the NYC hospitals nearly $900 million over the next 10 years. These are the same hospitals we are relying on to prepare for nuclear, biological, and chemical attacks, yet each has received only a little over $100,000 from HHS for emergency preparedness, and the President's FY05 budget included a cut in preparedness funding. It is these teaching institutions, and those in a handful of other states, that we rely on to train the vast majority of doctors for the nation's health care institutions and to be prepared in the event of another terrorist

attack. Instead of investing in these institutions, we have cut reimbursements by millions of dollars, making some of the most financially fragile institutions in the country even more so. What will you do to change the course of investment in our nation's urban health care system?

Answer:

Urban hospitals are a critical part of our nation's health care system. These hospitals have a long tradition of serving the health care needs of people in their communities, including uninsured and underinsured Americans who are unable to pay for their care. The Medicare and Medicaid programs have a long history of assisting these safety net hospitals bear the cost of caring for the poor and uninsured. Through Medicare and Medicaid disproportionate share hospital payments and Medicare bad debt payments, the Department is able to direct funding to those hospitals that need it most. In addition, I understand that the recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided several payment and policy changes that helped urban acute care hospitals, including a financial incentive for hospitals to report quality measures.

As Secretary, I will vigorously support this Administration's efforts to protect the nation from terrorist attacks. As you may know, since 2002, Congress has provided HHS with $3.8 billion in funding to upgrade our public health and hospital emergency preparedness capabilities. During this same period, the amount awarded to NY for these purposes is $229.4 million to New York State -- including funds directly awarded to New York City. Since 2002, when HHS began administering the National Bioterrorism Hospital Preparedness Program, the City of New York has received almost $30 million to prepare hospitals and related entities for bioterrorism and other public health emergencies. These investments have resulted in significant improvements in the Nation's ability to respond to both naturally occurring emergencies and terrorist events.

I look forward to working with the Congress to address the many continuing as well as changing demands on our healthcare system to address public health emergency preparedness.

Given that Medicaid serves 24 million children and is the principle source of health insurance for low-income children, it makes sense for the schools to serve a central role in helping students receive the services that they need. However, CMS has never issued clear, specific regulations about Medicaid reimbursements for services provided by schools, as the Agency has for a variety of providers who receive Medicaid payments.

The HHS Office of the Inspector General has initiated a series of audits of Medicaid claims submitted by New York schools for school-based services as far back as the early 1990s. Certainly, the OIG plays a key role in preventing the gross misuse of federal funding and in identifying instances of intentional fraud and abuse. However, in the case of the audits of New York school-based Medicaid claims currently being conducted, the problems seem to

stem from the lack of clear school-specific Medicaid regulations at the federal level. Only a portion of the audits have been completed, but the OIG has already recommended that New York repay hundreds of millions of dollars in past reimbursements.

In my view, most of the problems being uncovered by these audits could be corrected through a clarification of Medicaid regulations. Will you commit to working with me to clarify these regulations and to work with the State and local school districts to understand and appropriately implement them going forward, rather than requiring New York to repay these critically-needed funds?

Answer:

I believe it is important to provide clear guidance to the states on Medicaid requirements and to work with the states to help them understand those requirements and appropriately implement them at the local level. I understand that clarifying guidance was provided by CMS to states in 1997 and again in 2003 related to school based services and school based administrative claiming. Additionally, CMS staff work with states on an on going basis to develop school based claiming plans and school based services state plan amendments.

With respect to the specific situation in New York State, I understand that the current reviews that are underway are as a result of concerns raised by the Department of Justice from various Qui Tam lawsuits that have been filed concerning school based claiming under the Medicaid program and that both the OIG and the CMS regional offices have ongoing reviews underway. As Secretary I will be happy to work with you on this important issue.

The National Institute for Occupational Safety and Health is tasked with implementing an important part of the Energy Employees Occupational Illness Compensation Program, in addition to its important research and training functions. It was Congress' intent in passing the Energy Employees Compensation Act of 2000 to provide for timely, uniform and adequate compensation for employees made ill from exposure to radiation, beryllium and silica, while employed at Department of Energy nuclear facilities or while employed at beryllium vendors and atomic weapons employer facilities.

NIOSH has been plagued with slow progress in carrying out its responsibilities to estimate radiation doses for workers employed in Department of Energy and atomic weapons employer facilities. These determinations are used by the Labor Department to make a science based judgment on compensation. Nationally, approximately 1/3 of the cases received by NIOSH have been processed in the 4 years since the law was enacted, and in my state of New York, fewer than 50% of the radiation dose estimates have been completed. We understand that they have been given a difficult task, and we also appreciate that they have had the full amount of resources they have requested.

What can be done to improve NIOSH's performance?

Answer:

NIOSH responsibilities under Energy Employees Occupational Illness Compensation Program Act of 2000 had to be fulfilled before NIOSH could begin processing claims. NIOSH had to hire staff, establish procedures and promulgate three rules to create the process and systems to run the program; a backlog was created because the program was receiving claims before processes were in place.

As of January 20, 2005, NIOSH has completed more than 50% of the claims from New York and nearly 40% of all claims received from the Department of Labor. In addition, the promulgation of the Special Exposure Cohort rule in May 2004 will speed determination of claims for which it is not possible to perform a dose reconstruction with sufficient accuracy. NIOSH will continue to strive to improve its performance.

MEDICARE DRUG BENEFIT FOR DUAL ELIGIBLES

What specifically do you plan to do to ensure that dual eligibles transition seamlessly from their Medicaid drug benefit into the new Medicare program?

If states initiate efforts that extend temporary drug coverage during the initial months of the Medicare drug benefit would you consider extending financial assistance to those states?

(If legislative authority is brought up) **If legislation was introduced to allow the Department to extend financial assistance to states who initiate temporary drug coverage through their Medicaid program would you support it?**

Answer:

Starting on January 1, 2006, full-benefit dual eligible and other low-income individuals will be provided drug coverage at little or no cost through the new Medicare drug benefit. Approximately six million full-benefit dual eligible individuals will automatically qualify for subsidies of premiums and cost-sharing amounts under the Medicare prescription drug benefit. I agree that it is critical that we work to ensure as smooth a transition as possible for the dual eligible population. As Secretary, this will be a priority of mine, and I hope to work with you as we move forward in these efforts, including to review any potential state-initiated efforts or potential legislation on this issue.

MONEY FOLLOWS THE PERSON (SMITH BILL)

The State of Oregon has been an innovator in creating a system that allows seniors and persons with disabilities to receive care in their home or community. I have been an ardent supporter of this program because I believe that Americans should be offered this choice -- a choice between institutional or community-based care. Unfortunately, many people are not given this opportunity because the requirements of the Medicaid program unfairly direct people into nursing homes.

Senator Harkin and I have a bill called "Money Follows the Person," which is modeled after a proposal developed by the Administration through its New Freedom Initiative. This bill would create authority for a demonstration program under Medicaid that would allow states to have their state and federal Medicaid funding "follow the person to either community-based services or nursing homes."

How can we work together to see that this bill become law this Congress?

Answer:

We consider this to be a high priority. The Administration has undertaken substantial efforts during the past two years to ensure that the "Money Follows the Person" proposal becomes law by including it in the FY 2004 and FY 2005 President's budgets. Most recently, we worked with

Congress to include the Money Follows the Person proposal with the House version of the Family Opportunity Act that passed the Senate last year. We will continue to work with you on this important initiative that will enable seniors and persons with disabilities to have greater choice and control over the services they receive.

Follow Up
I know Chairman Grassley also would like to advance his bill the Family Opportunity Act, which I strongly support, this Congress. Is the Administration willing to provide its support for both of these proposals this year?

Answer:

Last year we worked on a bipartisan basis with members of the House to include the Money Follows the Person proposal with the House and Senate version of the Family Opportunity Act.

MEDICAID COMMISSION

As a former Governor, I know you are well aware of the challenges facing the Medicaid program. Over the past few years since the nation's economy experienced a downturn, we all witnessed the flaws of the program become apparent. To help weather what we thought was a short-term storm, I worked for the passage of the fiscal relief package that this Committee included in its 2003 economic stimulus package. Unfortunately, that doesn't seem to have been enough, the program appears to have serious structural weaknesses.

Going back to my time in the Oregon Legislature when I oversaw the creation of the Oregon Health Plan, I have always been an ardent supporter of Medicaid. And now that the program is in trouble, I am prepared to help. My colleague Senator Bingaman and I are introducing a bill the week of January 24 that will establish a Medicaid Commission. This Commission is comprised of federal, state and local elected officials, and representatives from the advocacy, academic and provider communities. It will be tasked with the important job of reviewing the program both acute and long-term care and charting its course for the future. The program has effectively served America's low-income and vulnerable for 40 years ago. Now we must determine how it will continue to serve people for the next 40years. I know some would like to cap funding or block grant the program, but I believe those types of actions are premature. We can make a fundamental funding change if we haven't first determined how the program will operate – who will it serve, what benefits will it offer, and how will the services be delivered – these are important questions that must be answered.

Given the Administration's utilization of Commissions over the past four years to develop policy on most major initiatives – the economy and Social Security reform to name a couple – how can we work together to see this bill become law?

Answer:

I agree that Medicaid is a very important program that is in urgent need of reform. Not only will I take a close look at your bill, I would be happy to work closely with you and the other Members of the Committee on the best ways to repair Medicaid so that it can continue to serve and provide the necessary healthcare for our neediest populations.

MENTAL HEALTH

Domenici/Kennedy Mental Health Parity Legislation

Breaking down the stigma of mental illness and extending services to people who need help has become a personal cause for me and my family. Last year, I worked with my colleagues in the Senate and the President to pass the Garrett Lee Smith Memorial Act that established the first programs targeted on intervening and preventing youth suicide. Creation of these programs moved this country forward and I believe over time will save the lives of millions of our nation's youth people. I thank the President for all of his help and we hope that we will be able to build upon the $11.5 million Senator Specter secured for FY2005 by obtaining full funding in FY 2006.

However, much work remains. And for this Congress, I have committed to Senators Domenici and Kennedy that I will help them pass their Mental Health Parity bill. We must help employers and insurance companies realize that mental illness is as physical an illness as diabetes. I could more have told Garrett to buck-up and be happy than I could tell a diabetic to make insulin. That is why I will be working to see this important bill become law.

How will you work with me and Senator Domenici to advance this bill, which the President says he supports and wants to become law?

Answer:

I believe that parity between mental health and "physical" health services in health insurance is a laudable and appropriate goal. I share the President's and Secretary Thompson's commitment to working with Congress to address the concerns of patients. That said, given that there is not always a logical "apples to apples" way to compare mental health versus physical health services, I believe it will take an investment of time and energy to try and identify the right policy to address patients' concerns. I will certainly work with the Congress as they legislation on this issue.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Grandfathering Oregon's Waiver

Prior to passage of the federal welfare reform bill – TANF – the State of Oregon created a work-focused program through a waiver under the old welfare program AFDC. Under

this waiver, the State of Oregon obtained outstanding results. It was able to place people into well-paying jobs because they had the foundation from which to learn and advance. As you may know, the waiver expired in 2003. However, Secretary Thompson agreed to allow the State to continue to operate under it waiver at least until Congress reauthorized the TANF program.

I remain committed to helping the State of Oregon maintain its outstanding welfare-to-work program. This can be accomplished by extending Oregon's current waiver or by expanding the definition of work and extending the time allowed to be spent in these additional activities for all states.

As a former governor I am certain you understand the importance of providing people with a solid foundation from which to enter the workforce. Not only does this benefit the individual, it helps ensure employers get qualified employees. How can we work together to ensure that the Oregon waiver is extended or to modify the Administration's position to incorporate the basic tenets of Oregon's program?

Answer:

I thank you for raising with the Administration your concerns about your State's TANF program and its waiver. I know that your efforts in support of Oregon's program are grounded in the lessons you have learned from the evaluation of your State's successful welfare reform program. Like many States, Oregon received a waiver of rules under the old Aid to Families with Dependent Children (AFDC) program in order to implement welfare reform. As you know, Oregon's waiver expired at the end of June, 2003. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), States were allowed to continue their old AFDC waivers until they expired, but HHS did not have the authority to extend the waivers. Therefore, we were not able to provide Oregon with additional time to transition to the TANF work requirements.

Even without its waiver, TANF does not prohibit Oregon from engaging clients in a wide range of activities aimed at promoting self-sufficiency, nor does it prohibit the State from assigning hours for particular clients at levels below the current-law hour standard. These issues are relevant in that States must meet minimum participation rates. However, under current law, Oregon receives a caseload credit for having moved so many families off of the welfare rolls into self-sufficiency. In FY 2003, this reduced Oregon's participation requirement from 50% to zero for the all-family rate. Therefore, Oregon would have met the all-family participation rate even if its waiver had not been in effect for any of the fiscal year.

I ask you to continue working with me to complete reauthorization legislation that will improve TANF for families across the nation. The welfare reform bills that were passed by the House and by the Senate Finance Committee last year, while differing in some details, both contained several provisions proposed by the Administration that would allow such activities as substance abuse treatment, mental health counseling, and adult literacy to fully count towards the work participation requirement for a limited period of time. Thereafter, such activities could continue to count when combined with direct work activities. These are exactly the kind of initial and blended activities that have been part of Oregon's successful program.

Disproportionate Share Hospital (DSH) Payments

Governor Leavitt, I am sure you must be familiar with the disproportionate share hospital (DSH) payment system from your experience with health care providers during the years you led the state of Utah and the National Governors Association. As you know, DSH payments are critical payments for hospitals which provide a disproportionate percentage of care for Medicaid and other low income individuals. DSH regulations can often be very confusing, even for CMS, the agency which administers the program that you will oversee once your nomination is complete. For the past few months, I have been working to assist hospitals in my state that have been negatively impacted by what I have found to be CMS' inconsistent interpretations of the DSH statute and its own regulations.

Specifically, I am interested to learn whether, if confirmed, you would be committed to work with us to develop more certainty in CMS' interpretations of the DSH statute, and in the ability of providers to be able to rely on what CMS Fiscal Intermediaries tell these providers to do in terms of how they make their DSH calculations? What assurances can you provide us that CMS will be able to provide our hospitals with meaningful guidance and hold hospitals harmless that rely in good faith on instructions they have received from those who function as CMS' agents in the states, the Fiscal Intermediaries?

Answer:

It is important that all of the health care providers serving Medicare beneficiaries feel confident in the advice that they received from Medicare's claims processing contractors, including the Fiscal Intermediaries (FIs). With the new contracting authorities established in the Medicare, Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Medicare program will now be able to use competitive contracting methods to ensure that the best contractors are providing service to Medicare's providers and beneficiaries. I am hopeful that, as contracting reform moves forward, providers will feel more confident that the best qualified and most reliable contractors are chosen to assist them.

Additionally, it is my understanding that there are several steps that are currently being taken to address contractor errors in the future. Section 903 of the MMA recognizes that providers should not be penalized for relying upon the erroneous guidance received from their Medicare contractor. For guidance provided after July 24, 2003, the provision states that the collection of penalties and interest are prohibited if a provider follows written, erroneous guidance from the government and its agents, including guidance provided by Medicare claims processing contractors. Although this provision is not applicable to the current situation in Maine, it should address similar situations in the future.

I would like to provide you with more actual case histories as to how the CMS DSH policies are not working. Would you be willing to work with us and develop a policy that is fair to all parties?

Answer:

As Secretary, I would be more than willing to work with you to ensure the policies CMS has in place regarding Medicare's disproportionate share hospital (DSH) payments are fair and equitable. Safety net hospitals are a critical part of our nation's health care system. These hospitals have a long tradition of serving the health care needs of people in their communities, including uninsured and underinsured Americans who are unable to pay for their care. I am always interested to hear suggestions for how policies can be made better. Please do not hesitate to share your thoughts and ideas with me.

Disproportionate Share Hospital (DSH) Payments to Maine Hospitals

Governor Leavitt, we have a situation in Maine that involves the Medicare DSH adjustment and a number of Maine hospitals who are caught in a quagmire which has resulted from incorrect instructions they received from a Medicare Fiscal Intermediary (FI).

In the mid 1990s, Maine hospitals appealed Medicare's calculation of their DSH percentage and proved that certain dual-eligible Medicaid patients, known in Maine as non-SSI Type 6 patients (dual-eligibles without Supplemental Security Income coverage), were not being counted in the DSH calculation which provides increased reimbursement for providing care for treating Medicaid patients. The FI in Maine initially refused to count these patients but eventually advised the hospitals it was authorized to settle appeals. The FI then instructed Maine hospitals to include these patient days in their DSH calculations, and the hospitals understood that the Intermediary, consistent with past practices, had obtained CMS' approval in providing this advice.

From 1997 to 2003, Maine's hospitals relied on the intermediary's advice and made its DSH calculations pursuant to the FI's written instructions. Now, however, CMS has concluded that those instructions were wrong, and the agency is attempting to recover a lump sum repayment of $25-30 million from these hospitals, an enormous sum that would be financially devastating to these hospitals that serve a disproportionate share of Maine's most vulnerable citizens.

As a Senator I can't conclusively determine the accuracy of the Fiscal Intermediary's advice, but it is my understanding that the advice was formally given to those hospitals with the approval of CMS. It is also undisputed that a number of appeals from prior years were actually settled by the Fiscal Intermediary based upon this advice. Despite these facts, the hospitals were notified again this month that the CMS' collection efforts would proceed.

It is inconceivable to me that these hospitals, acting on the information and advice of the CMS agent, must now repay this very large sum as a result of the Fiscal Intermediary's error. This is even more incredible given that hospitals in other states in this situation have, without exception, been held harmless. Finally, the Medicare Modernization Act recently passed by Congress clarifies that institutions would not be held liable for penalties or interest resulting from incorrect FI instructions.

CMS has previously held harmless hundreds of hospitals in other states for improperly including certain patient days in the Medicaid fraction because the "guidance on how to claim these funds was not sufficiently clear." In Maine, the patient days at issue were undisputedly Medicaid-eligible, and the fiscal intermediary gave clear instructions on how to count them. It is also beyond dispute that the hospitals fully disclosed their position through their appeals. Given that other states in this situation have been held harmless, how would you address CMS's inconsistent actions in refusing to hold Maine hospitals harmless while forgiving over $1 billion dollars of overpayments in other states?

Answer:

I appreciate your concerns and understand that the Maine hospitals have been working with CMS on this issue. I have been told that CMS does not have the legal authority to waive any overpayments and that the statute and regulations explicitly state that the days associated with patients entitled to Medicare Part A should not be included in the numerator of the Medicaid fraction. I understand that the policy regarding the disallowance of Medicare Part A days in the Medicaid fraction has been in the statute and enforced for many years. To disregard it would ignore the Department's obligation to protect the Trust Fund and would be unfair to the many other hospitals that have followed the policy. At the same time, if confirmed, I would be happy to investigate the situation further to be sure that the policy is being interpreted appropriately.

I recognize the importance of assuring that Maine hospitals are able to continue their work serving the nation's most vulnerable populations. I understand that CMS is working with the hospitals on a repayment plan to ease the financial impact on them. The hospitals have also been informed that they may opt to request an extended repayment plan.

I am not familiar with the specifics of the situations surrounding the other overpayments that you have cited. As Secretary, I will certainly look into the situation to determine if there has been some discrepancy here.

It has come to our attention that prior to 2003, the Intermediary failed to count several categories of Medicaid-eligible patients in the DSH calculation. Although CMS now intends to reopen closed or settled cost reporting periods to reduce Medicaid-eligible days, it is not clear that CMS will likewise insist upon the

inclusion of the previously omitted eligible categories. How will you address this situation?

Answer:

It is my understanding that CMS has historically reopened closed cost reports regardless of whether the expected change will be in the favor of the Medicare Trust Fund. However, due to the vast number of cost reports that the Medicare contractors examine annually, in the case of an underpayment, it is generally necessary that a provider make a specific request calling the error to the contractor's attention and asking that a cost report be reopened.

Leavitt Confirmation
Thomas Questions for the Record

As you may know, rural health care has always been one of my top priorities here in Congress. Should you win Senate confirmation, what strategies will you take to shore up our nation's fragile rural health care networks? Will you make health information technology a priority?

Answer:

I certainly appreciate and understand the unique challenges faced by rural providers. This Administration has made a strong commitment to rural health issues and has implemented many significant regulatory and Departmental reforms to promote rural health care providers. Also, as you know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA) included several provisions to enhance beneficiary access to quality health care services and improve payments in rural areas. As Secretary, I will ensure that rural health care issues remain a top priority and continue to receive the attention they deserve.

I believe that the federal government can play a critical role in encouraging and facilitating the adoption and use of health information technology, and I am keenly interested in this issue. And I am very confident that the use of health information technology nationally can and will move our health care industry forward, simultaneously improving efficiency and productivity and reducing overall health care costs. As you are well aware, rural and underserved areas across the country experience a unique set of challenges, especially in the area of health care. Unfortunately, these areas have the most difficult time recruiting and retaining health professionals to fulfill the health care needs of their communities. They are also less likely to have adopted health information technologies in their hospitals and may have limited resources for investing in these new technologies. As you know, the Health IT Strategic Framework identified some potential mechanisms to help support, or remove barriers to, the adoption of health IT, and encouraged further thought be given to these issues. As we consider ways to encourage the adoption and use of health information technology nationally, it is critical that we take into account the unique conditions in rural and underserved areas; and I look forward to working with you in this area.

Over the past few years, I've become very concerned about the overall costs of health care. While medical advancements in technology and drug therapies are good, we are making state-of-the-art health care unaffordable for many Americans – particularly those living in rural areas. Given your experiences, do you have any thoughts on what can be done to control costs?

Answer:

It is critical that we take steps to address the costs of health care. The President is committed to making quality health insurance more affordable and more accessible for millions of American working families. For low-income families, the proposal includes refundable tax credits to enable families to buy coverage. It also includes $4 billion in Federal grants to States to establish purchasing pools - or to expand existing pools - where people could use their tax credits to buy coverage. In addition, he's proposed to allow tax credit recipients to divide their assistance

between a premium subsidy and a government contribution to a health savings account, and to make it easier for employers to provide health insurance through association health plans.

The President has also proposed common-sense medical liability reform to protect patients, to stop the sky-rocketing costs associated with frivolous lawsuits, to make health care more affordable and accessible for all Americans, and to keep necessary services in communities that need them most. The President's plan seeks to make the medical liability system more stable and predictable, and to protect patients by reducing the disincentives for reporting medical errors and complications.

The President believes that better health information technology is essential to his vision of a health care system that puts the needs and the values of the patient first and gives patients information they need to make clinical and economic decisions. Innovations in electronic health records and the secure exchange of medical information will help transform health care in America - improving health care quality, preventing medical errors, reducing health care costs, improving administrative efficiencies, reducing paperwork, and increasing access to affordable health care.

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006. HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years.

As Secretary, I plan to continue to work to make health care more affordable and accessible for all Americans.

As Congress and the Administration make a move toward enforcing more fiscally responsible spending, how do you feel this will impact the Medicare and Medicaid programs? Is there a way to reign in entitlement spending without hurting our most vulnerable populations?

Answer:

I agree with you that the Department of Health and Human Services provides the most vulnerable Americans with important, sometimes life-saving services. I do not believe that anyone is suggesting that we eliminate such services. Rather, we must all be accountable to federal taxpayers about how efficiently those services are being delivered, the quality of those services, the outcomes for our most vulnerable citizens when they receive those services, and, unfortunately, whether there is abuse, overpayment or waste in the underlying programs. I look forward to working with you on these critical issues.

One comment on the Medicare bill, which you will be responsible to implement in 2006: Have you had time to think about how to ensure the new private Medicare Advantage and

Prescription Drug Plans can be implemented so rural seniors have the same types of choices as their urban counterparts?

Answer:

The Medicare Modernization Act (MMA) made many changes to the Medicare Program that will benefit beneficiaries in rural areas. By 2006, the MMA will provide America's seniors and disabled with a substantial new drug benefit. This access to prescription drugs will improve the health of millions of Americans but will especially benefit those in rural areas. Rural beneficiaries have higher out of pocket drug costs than beneficiaries in urban areas. And while almost 80 percent of beneficiaries in urban areas already have some prescription drug coverage, only two-thirds of beneficiaries in rural areas have such coverage.

The MMA also authorized a new system of regional preferred provider organization (PPO) plans to bring new plan choices to rural areas and give those beneficiaries the same options that their urban counterparts have enjoyed. The 26 Medicare Advantage regions for the new regional PPOs have been designed to maximize access to plans and providers especially for beneficiaries in rural areas who have traditionally had fewer Medicare plans from which to choose. The establishment of the regions will bring not only more choices, but also more benefits and more savings to millions of Medicare beneficiaries. The MMA also gives CMS several tools to attract and retain regional PPOs in rural areas, including start-up risk corridor payments, an entry and retention fund, and special payments to essential hospitals treating regional plan enrollees.

Folks in my state consistently talk to me about the high cost of prescription drugs. One issue that I am sure will garner much focus during the next Congress is reimportation of prescription drugs from Canada. Can you please explain your position on this matter?

Answer:

The HHS Drug Importation Task Force authorized by MMA produced a thorough report of all of the issues surrounding drug importation. The report discusses a number of complex issues and identifies eight key findings. I plan to review the report carefully. It is important to note that significant safety concerns prevented Secretary Thompson and former Secretary Shalala from certifying an importation program. Additionally, in his letter accompanying the Task Force report to Congress, Secretary Thompson indicated that implementation of a limited commercial importation program from Canada would require, among other things, significant additional new resources and authorities and would produce limited savings to U.S. consumers.

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more

than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to work to make high-quality prescription drugs more affordable and available for all Americans.

If reimportation is not the answer to lowering drug costs in the states, do you have thoughts on what actions should be taken?

Answer:

The Bush Administration has worked closely with Congress on a bipartisan basis to enact important legislation to address the high cost of prescription drugs. Most significantly, the President worked with Congress to pass the landmark Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which will make prescription drug coverage available to every senior in 2006.

HHS has worked to lower drug costs for millions of Americans by strengthening competition between generic medications and brand-name drugs. These efforts will save Americans more than $35 billion in drug costs over 10 years. As Secretary of HHS, I plan to continue to work to make high-quality prescription drugs more affordable and available for all Americans.

The Medicare Modernization Act included a provision for $12 billion to increase payments to Medicare health plans to establish PPOs in areas which otherwise are not covered. The provision also authorized the Secretary of HHS to make final decisions on spending money from this fund. Rather than pay health plans, would you as Secretary consider using this money for direct financial incentives to physicians and other health care providers to encourage them to join PPOs in order to insure that areas normally not covered by health plan do have Advantage PPOs, so beneficiaries have a choice?

Answer:

Starting in 2007, the Medicare Modernization Act (MMA) provides for a stabilization fund (initially funded at $10 billion) that will be available to Medicare Advantage regional plans to encourage plan entry and retention across the country. Such funds provided to MA regional plans will be used in various ways, including increasing benefits or increasing provider access, which means MA plans could use this funding to increase their payments to providers. Also, the MMA specifies that $25 million a year be made available to "essential hospitals" that treat regional Medicare Advantage plan enrollees. Acute care hospitals that do not have a contract with a regional Medicare Advantage plan, but which treat Medicare Advantage regional plan enrollees, can be paid an additional amount if they show that their costs for providing care to a Medicare Advantage regional plan enrollee exceeded the amount that Medicare would normally pay for such a service.

Some in the health care community are concerned that regulatory and enforcement activities of the individual state insurance commissioners may decrease the ultimate effectiveness of the Advantage programs and plans envisioned by the MMA. As Secretary would you at least be vigilant about this potential problem and if need be look at rule making or even legislation to better coordinate federal and state regulatory activity?

Answer:

As you know, The MMA amended section 1856(b)(3) of the Act relating to federal preemption of state law. That section specifies that federal standards will supersede any state law or regulation other than state licensing laws or state laws related to plan solvency. Prior to this change, federal preemption of state law would not apply, in many areas, unless the relevant state law conflicted with Medicare plan requirements. Nonetheless, I will work with CMS to be attentive to any potential problem in this area.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Arkansas

- As of early January 2005, total drug card enrollment in Arkansas is approximately 78,000 beneficiaries.

- There are about 78,000 enrolled in the General Drug Cards and about 86 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 34,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Arkansas Medicare population, which is approximately 77,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Arizona

- As of early January 2005, total drug card enrollment in Arizona is approximately 170,000 beneficiaries.

- There are about 31,000 enrolled in the General Drug Cards and about 140,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 17,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Arizona Medicare population, which is approximately 120,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Idaho

- As of early January 2005, total drug card enrollment in Idaho is approximately 23,000 beneficiaries.

- There are about 23,000 enrolled in the General Drug Cards and about 110 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 6600 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Idaho Medicare population, which is approximately 30,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

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- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Iowa

- As of early January 2005, total drug card enrollment in Iowa is approximately 47,000 beneficiaries.

- There are about 41,000 enrolled in the General Drug Cards and about 5400 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 19,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Iowa Medicare population, which is approximately 110,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

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- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Kentucky

- As of early January 2005, total drug card enrollment in Kentucky is approximately 100,000 beneficiaries.

- There are about 94,000 enrolled in the General Drug Cards and about 10,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 43,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Kentucky Medicare population, which is approximately 110,,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

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- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Maine

- As of early January 2005, total drug card enrollment in Maine is approximately 15,000 beneficiaries.

- There are about 15,000 enrolled in the General Drug Cards and about 59 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 7800 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Maine Medicare population, which is approximately 39,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

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- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Massachusetts

- As of early January 2005, total drug card enrollment in Massachusetts is approximately 92,000 beneficiaries.

- There are about 58,000 enrolled in the General Drug Cards and about 34,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 37,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Massachusetts Medicare population, which is approximately 160,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Mississippi

- As of early January 2005, total drug card enrollment in Mississippi is approximately 92,000 beneficiaries.

- There are about 92,000 enrolled in the General Drug Cards and about 91 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 54,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Mississippi Medicare population, which is approximately 74,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

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- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Montana

- As of early January 2005, total drug card enrollment in Montana is approximately 12,000 beneficiaries.

- There are about 12,000 enrolled in the General Drug Cards and about 50 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 5,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Montana Medicare population, which is approximately 24,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in New Mexico

- As of early January 2005, total drug card enrollment in New Mexico is approximately 50,000 beneficiaries.

- There are about 26,000 enrolled in the General Drug Cards and about 24,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 11,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of New Mexico Medicare population, which is approximately 43,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in New York

- As of early January 2005, total drug card enrollment in New York is approximately 230,000 beneficiaries.

- There are about 190,000 enrolled in the General Drug Cards and about 47,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 130,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of New York Medicare population, which is approximately 470,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in North Dakota

- As of early January 2005, total drug card enrollment in North Dakota is approximately 12,000 beneficiaries.

- There are about 11,000 enrolled in the General Drug Cards and about 270 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 5500 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of North Dakota Medicare population, which is approximately 18,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Oregon

- As of early January 2005, total drug card enrollment in Oregon is approximately 66,000 beneficiaries.

- There are about 37,000 enrolled in the General Drug Cards and about 29,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 17,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Oregon Medicare population, which is approximately 87,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Pennsylvania

- As of early January 2005, total drug card enrollment in Pennsylvania is approximately 500,000 beneficiaries.

- There are about 160,000 enrolled in the General Drug Cards and about 340,000 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 160,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Pennsylvania Medicare population, which is approximately 360,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Tennessee

- As of early January 2005, total drug card enrollment in Tennessee is approximately 94,000 beneficiaries.

- There are about 94,000 enrolled in the General Drug Cards and about 150 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 31,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Tennessee Medicare population, which is approximately 150,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Utah

- As of early January 2005, total drug card enrollment in Utah is approximately 18,000 beneficiaries.

- There are about 18,000 enrolled in the General Drug Cards and about 190 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 4400 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Utah Medicare population, which is approximately 37,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Vermont

- As of early January 2005, total drug card enrollment in Vermont is approximately 2900 beneficiaries.

- There are about 2900 enrolled in the General Drug Cards and about 18 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 340 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Vermont Medicare population, which is approximately 16,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

- Medicare Advantage plans are permitted to auto-enroll their members into exclusive drug cards. Reflecting their high levels of MA availability, California, Florida, Hawaii, Minnesota, Missouri, Nevada, New Mexico, Ohio, Pennsylvania and Washington have a high number of MA exclusive card enrollees.

- State Pharmacy Assistance programs (SPAPs) are also permitted to auto-enroll their low-income members. SPAP auto-enrollment accounts for about 29 percent of enrollment in the drug cards with transitional assistance. Ten states' SPAPs are auto-enrolling their participants: Connecticut, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania and Rhode Island. Ohio sent pre-filled drug card applications to their beneficiaries who qualify for TA.

- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in West Virginia

- As of early January 2005, total drug card enrollment in West Virginia is approximately 40,000 beneficiaries.

- There are about 37,000 enrolled in the General Drug Cards and about 2600 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 16,000 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of West Virginia Medicare population, which is approximately 59,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

- State Health Insurance Assistance Programs (SHIPs) play a factor in the general card enrollment. States with high levels of active SHIP drug card outreach appear to have higher general and TA enrollment. For example, the North Carolina SHIP has been a major force in a state-wide initiative to outreach and enroll low-income beneficiaries. The SHIP has delivered training to 1,000 aging service providers and pharmacy students at the local university and held Senior Care Sign-Up Day in October at 126 various sites. As a result of their outreach, thousands of low-income beneficiaries have enrolled in North Carolina.

- Outreach efforts by other organizations using consistent, well-developed education materials have also supported enrollment in some states. For example, in Ohio, The Cleveland Department of Aging, who also directs the Greater Cleveland Access to Benefits Coalition, worked with church groups, public housing organizations and other non-profits groups and have enrolled over 1,200 beneficiaries in the six county areas around Cleveland; and another group the National Asia Pacific Center on Aging, based in the Seattle metropolitan area, established help lines and produced materials for non-speaking English beneficiaries and nationally enrolled over 1,000 beneficiaries eligible for transitional assistance.

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- In states where a large number of beneficiaries reside in a few areas within the state, outreach events can more effectively target beneficiaries in these specific areas to encourage drug card enrollment. Alabama, Georgia, Mississippi and Kentucky are examples of states with a significant population residing in a limited number of areas within the state and in which targeted outreach efforts in the state may have contributed to higher drug card enrollment rates. For example, an Area Agency on Aging in Georgia held an event for more than 750 seniors at a local fairground that included skits and booths. They estimate that over 500 seniors signed up for the drug card as a result of this event.

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SENATE FINANCE COMMITTEE
DRUG CARD ENROLLMENT

Drug Card Enrollment Nationally

- As of early January 2005, total national drug card enrollment is almost 6 million. There are approximately 3.5 million that are enrolled in General Drug Card and 2.5 million enrolled in the Medicare Advantage Exclusive Drug Cards.

- 1.6 million of these drug card enrollees are low-income and receiving the $600 annual credit plus large additional discounts on many brand-name drugs.

Drug Card Enrollment in Wyoming

- As of early January 2005, total drug card enrollment in Wyoming is approximately 7,000 beneficiaries.

- There are about 7,000 enrolled in the General Drug Cards and about 49 enrolled in the Medicare Advantage Exclusive Drug Cards.

- Approximately 2600 of these drug card enrollees are low-income and receiving the $600 additional credit.

Factors That Lead to Increased Drug Card Enrollment in States

The Medicare Prescription Drug Discount Card is an urgent, temporary program to provide assistance with lower drug costs for Medicare beneficiaries without drug coverage until the full Medicare drug benefit becomes available in 2006. Altogether, about one-fourth of Medicare beneficiaries do not have drug coverage today. For voluntary health benefits like Medicare Savings Program and SCHIP coverage, prior experience indicates that, over time, about half of eligible individuals will enroll in the program.

This experience would suggest that over time about 7 million Medicare beneficiaries without drug coverage might enroll —about one-sixth of Wyoming Medicare population, which is approximately 12,000. However, it typically takes some time for beneficiaries to find out about a new voluntary program and make the decision to enroll. For example, SCHIP enrollment at the end of its first year, CMS projected enrollment at 2.2 million but its actual uptake was 1.2 million, about half of projection.

Consequently, from the historical standpoint, the enrollment experience with the Medicare drug card has been very favorable, with millions of beneficiaries getting billions in discounts and financial assistance with drug costs in the program's first six months. However, enrollment experiences appear to have varied somewhat across states, with some states having very rapid enrollment of relatively large numbers of beneficiaries.

The following points describe some of the major factors impacting enrollment in the Medicare Prescription Drug Discount Card program, as well as the Transitional Assistance (TA) program that provides the $600 annual credit for low-income individuals.

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- State clearinghouses provide residents with information about the drug card program also contribute to higher drug card enrollment rates. Alabama has such a state drug card clearinghouse.

PREPARED STATEMENT OF HON. BLANCHE L. LINCOLN

I am pleased to consider the President's nomination of former Governor Michael Leavitt to be Secretary of Health and Human Services (HHS). As Secretary, he will face an enormous task—overseeing the implementation of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). He will also oversee Medicaid, the Federal-State program which provides medical and long-term care services for millions of low-income families and individuals, especially our elderly in nursing homes.

The MMA, which I supported, establishes a Medicare prescription drug benefit program, providing seniors and individuals with disabilities with long overdue prescription drug coverage starting on January 1, 2006. The success of this new program depends upon the work of the Center for Medicare and Medicaid Services (CMS) not only this year, but throughout the implementation process.

This year is a historic one for Medicare beneficiaries. Beginning on November 15, 2005, all Medicare beneficiaries will be given the opportunity to enroll in a Medicare drug benefit. It is critical that we use the time between now and then to educate current and future beneficiaries about this complex benefit and other changes in the Medicare program.

I and many others have been disappointed in the low enrollment in the Medicare drug discount card. December 8, 2004 was the one-year anniversary of the MMA becoming law, and the news was not good. In 2004, only 1.5 million low-income Medicare beneficiaries enrolled in a drug discount card (which has $1,200 worth of direct subsidy for drugs for people under 135 percent of poverty) out of the estimated 7.1 million people eligible. That means that 5.6 million people essentially left $600 on the table in 2004. In 2004, only 5.8 million Medicare beneficiaries nationwide enrolled in a drug discount card out of the approximately 40 million beneficiaries eligible. Most of these beneficiaries were signed up automatically through a Medicare managed care plan, which we do not have in Arkansas.

Given the low enrollment in the drug discount card and the fact that many beneficiaries do not even know that a Medicare drug benefit was passed into law, I do not have high confidence that many beneficiaries will be enrolled in a drug benefit by the time the enrollment period ends and premium penalties start to apply on May 15, 2006.

It is critical that CMS and its partners, like the Access to Benefits Coalition, work hard to inform current beneficiaries that premium penalties will apply after May 15, 2006 if they fail to sign up for a drug plan. I believe Congress should consider extending this deadline, particularly for low-income beneficiaries, who are often harder to reach.

I also believe that CMS should exercise the authority it has and automatically enroll participants in the Medicare Savings Program in a drug benefit plan if they fail to enroll in one themselves, an authority they will exercise for those beneficiaries who participate in both Medicare and Medicaid (the so-called "dual eligibles"). Only about 7 million beneficiaries will be automatically enrolled in the low-income subsidy out of the estimated 14.1 million beneficiaries who are eligible for it. This generous low-income assistance, which will pay for between 85 to 100 percent of prescription drug costs, is largely the reason why I supported the MMA. It is estimated that almost half of the Medicare beneficiaries in Arkansas will qualify for the low-income benefit. It is absolutely critical that we find all these people and enroll them. Arkansans have much to gain by this new law, if we can only reach them.

I have often been impressed by the fact that Medicare beneficiaries consistently describe Medicare as a "lifeline." While the program remains popular, the recent changes in Medicare have caused much confusion, and the drug discount card has eroded some faith in Medicare. I am concerned that the General Accountability Office found that callers to the 1–800–MEDICARE help line got accurate answers only 61 percent of the time. Of the remainder, 29 percent were given erroneous or incomplete information, and 10 percent of the calls weren't answered at all, as callers were disconnected. I hope that CMS will learn from its experiences with the drug discount card. Seniors and their families need to have confidence in the new Medicare drug program—it is vital to its success.

In addition to Medicare, Medicaid is a critically important program to Arkansans. Nationwide, Medicaid finances services for over one in three births; over one in four children; one in five of all non-elderly individuals with specific, chronic disabilities; and two in three residents in nursing homes. In Arkansas, half of the births are financed by Medicaid. Providing coverage for 50 million individuals, Medicaid is a crucial safety net that many Americans rely on for health care and long-term care. I am concerned that any arbitrary caps on funding for this program will negatively impact the health care these Americans currently receive.

I would like to share a quote with all of you. "To balance the Federal budget off the backs of the poorest people in the country is simply unacceptable. You don't pull the feeding tubes from people. You don't pull the wheelchair out from under the child with muscular dystrophy." This is a direct quote from Arkansas' Governor Mike Huckabee in response to potential Medicaid funding cuts in the President's budget. I couldn't say it better myself.

States all over the country are being impacted by decreased revenues and are being forced to make tough choices. At the same time, enrollment in Medicaid is increasing. In fact, compared to other States, enrollment in Medicaid in Arkansas is growing at one of the fastest rates. Monthly Medicaid enrollment grew by 9.6 percent from June 2002 to June 2003, while the national average was 5.9 percent. I am concerned that budget cuts will exacerbate this already difficult situation, and I look forward to working with the Administration to ensure that this important safety net is not jeopardized.

PREPARED STATEMENT OF HON. TRENT LOTT

Good afternoon. I'd like to thank Chairman Grassley for chairing this hearing, and Governor Leavitt for appearing before the Committee to discuss his nomination to be the new Secretary of HHS.

Governor Leavitt, I would like to congratulate you on both your nomination to be Secretary of HHS and also your past accomplishments as governor of Utah, and as administrator of the EPA. Under your leadership Utah was named the "best managed State in America" and the "best place to locate a business." You successfully led the reduction of income, sales, and property taxes while serving in office.

However, a more pertinent example of your leadership while governor was made evident by the extension of the Medicaid plan to cover 25,000 more Utahns without any additional State costs. This accomplishment was done with the help of a waiver from HHS; this waiver was the first of its kind under the Bush administration's Health Insurance Flexibility Initiative to trim Medicaid coverage for optional beneficiaries in order to extend benefits to more people. This strategy was based on the ability to provide basic health care to many Utahns rather than unlimited health care to a few.

You were also very helpful to us when we passed important reforms to our welfare laws in 1996. The end result of that bill has been a decrease by about 50 percent of the Nation's welfare roles, and a large savings on behalf of the government.

Finally, you and I have discussed an issue important to me regarding Singing River Hospital in Pascagoula, Mississippi. Based upon our conversation, I am confident that you will work with me to find creative solutions for the problems facing Singing River due to the 2002 census reclassification.

I am certain that you will continue to be a strong and innovative leader for the Department of Health and Human Services. I look forward to working with you as Secretary, and congratulate you for your nomination.

PREPARED STATEMENT OF HON. GORDON H. SMITH

Thank you, Mr. Chairman, for hosting today's hearing to discuss Administrator Michael Leavitt's nomination to become Secretary of the Department of Health and Human Services. As we begin the new Congress, I am pleased to know that the Department will continue to rest in very capable hands.

First, let me say what a pleasure it is to see you again, Governor Leavitt. I enjoyed the conversation we had before the Christmas holidays and am confident you will make an outstanding Secretary of Health and Human Services. Given your experience as the governor of Utah for 8 years, I am confident that you will be able to take the helm of the Department and continue to guide it through this very challenging, but exciting time.

As you are well aware, many cornerstone issues exist for the agency and in fact our country—establishment of the new Medicare prescription drug benefit, improvement and stabilization of the Medicaid program, oversight and possible restructuring of the Food and Drug Administration. Alone any one of these issues would be a challenge, but facing all at the same time certainly will keep us busy and demand a concerted effort to ensure all are done properly.

The Finance Committee has a storied history of working with the Department. We work together to help oversee the programs for which this Committee has jurisdiction, including Medicare, Medicaid, SCHIP, child welfare, TANF and disability issues to name just a few. We must work with the Secretary to ensure that the in-

tentions of the Congress are in fact carried out by the agency staff. I am confident a strong working relationship will continue and look forward to working with you.

The first challenge that I believe you will face as the new Secretary is creation of the Medicare prescription drug benefit. I think it is safe to say that the agency was put on a very short timeline to roll-out such a major benefit. In fact, the bill we passed in 2003 was the largest single expansion of the Medicare program since its creation. While good progress has been made, I am especially concerned that the transition of the so-called dual eligibles be seamless. Over 6.1 million Americans who are our poorest, sickest and most vulnerable are categorized as dual-eligibles. They are the people residing in nursing homes, living with chronic diseases such as mental illness, HIV-AIDS, diabetes, and persons with disabilities. However, to their family they are just loved ones who need extra assistance to remain healthy and alive. We must expend additional resources to determine if it is possible to enroll everyone in an appropriate drug program by January 1, 2006. If this isn't possible, we must create a contingency plan to allow a temporary Medicaid benefit to bridge the gap. I look forward to working with you to see that this happens.

As the largest single source of long-term care, Medicaid plays a singular role in helping the elderly and disabled. While most experts agree that the least restrictive setting is the best setting to deliver assistance, the Medicaid program remains out-of-date because of its bias toward placing people in institutional settings. I have a bill called "Money Follows the Person" that would help States remove this bias by allowing both Federal and State Medicaid funding to "follow" people into the least restrictive, most appropriate setting. This bill is modeled after the President's New Freedom Initiative, and I am hopeful that as the new Secretary you will personally help champion its adoption into law.

Now, if I may, I'd like to talk about an issue that doesn't fall under Finance's jurisdiction, but is important nonetheless. I'm talking about mental illness. Most are aware that with the strong support of the President I was able to see the Garrett Lee Smith Memorial Act signed into law on October 21. It was a momentous occasion for Sharon and me, yet we know that the battle isn't yet won. We have many challenges ahead. The first is securing full funding for the Act. I understand that the President's budget because of timing problems—the bill became law after HHS completed its budget—may not include a fiscal year 2006 funding request. I look forward to working with you to remedy that oversight and secure full funding—$27 million—from the appropriations process.

With passage of Garrett's bill comes an opportunity to do even more to help persons with mental illness. We must enact mental health parity legislation this year. I have committed that I will champion this cause with its leaders, Senators Domenici and Kennedy. No longer can insurance companies treat mental illness differently than physical illnesses. I could no more tell Garrett to buck-up and be happy than I could tell a diabetic to produce insulin. His bipolar disorder was as lethal to him as cancer is to a leukemia patient. This bill must be passed, and now is the time for the President to exert pressure on the House of Representatives to see that it happens.

Another important challenge is the long-term financing of Medicaid. I know much has been said about balancing the budget, and I support those efforts because it is good for our economy; however, it cannot come on the backs of the poor, disabled and aged. Senator Bingaman and I have a bill that calls for the creation of a Medicaid Commission so that Federal, State and local officials can debate the issues and make recommendations about the future course of this program. Medicaid has served our country well for 40 years, now we must determine its future. Governor Leavitt, I hope you will champion this bill.

While the next two issues unfortunately are left over from the previous Congress, nevertheless they require your focused attention—reauthorization of TANF and extension of SCHIP funding. States have continued to operate under temporary extensions of the TANF program since 2002. Needless to say, this has put a great burden on States; I know I have heard about it from my State of Oregon. The uncertainty has limited States' ability to try innovative solutions, and coming at a time when the economy took a downturn has added additional stress. Oregon has a unique and very effective program that helps hard-to-employ people establish a solid foundation before entering the workforce. I hope as Secretary of Health and Human Services, you will work with me to incorporate Oregon's waiver into the legislation or at a minimum fight with me to modify the Senate package to expand the definition of work and increase the amount of time allowed in basic skill development programs.

Regarding SCHIP, almost $1.1 billion in needed, but unused SCHIP funding reverted to the U.S. Treasury last year. We must recapture that funding and put it back into circulation for the States to use in their SCHIP programs. I know Utah has a strong program thanks to your work as Governor, and we need your help now

as Secretary to recapture that funding so it can be used to improve enrollment in other States.

Finally, I would like to talk about two issues on which the Administration and I differ—importation of prescription drugs and expanding stem cell research. I would like to work with you on both of these critical issues, because they truly are life and death. I would like to urge the Administration's support of expanding the President's current stem cell policy to allow for the utilization of embryos from IVF facilities. We know that the existing lines are not adequate, many are corrupt and others didn't develop as expected. We must increase the number of lines available for research so we can find cures for Parkinson's, diabetes, and spinal cord injuries.

On importation, I hope we can work together to lift the ban on American consumers and legalize importation of prescription drugs. I know this is a controversial issue; however, I remain convinced that we must utilize all means to pressure foreign governments to increase their prices and begin shouldering their portion of the R&D costs for pharmaceutical development. Only then will the price of prescription drugs in the U.S. become more affordable.

Thank you for your time, Governor Leavitt, and I look forward to working with you in your new capacity as Secretary of the Department of Health and Human Services. I wish you the best of luck.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. CRAIG THOMAS

Thank you, Mr. Chairman, for holding today's nomination hearing on Michael Leavitt, to be the Secretary of Health and Human Services. I appreciate you taking swift action on this nominee, and look forward to an expedited confirmation process.

Welcome, Governor Leavitt. I am pleased that President Bush has selected a candidate who understands not only how Federal policies and programs affect rural areas, but who also approaches solutions by keeping local people's needs in mind. I look forward to your testimony.

As I travel throughout Wyoming, almost everyone I talk to—patients, doctors, hospital administrators, and small businessmen—agree our Nations' health care system is broken. Hospitals struggle with low public and private insurance reimbursement rates to collect revenues, providers cost shift to those with private insurance, the uninsured access emergency rooms for primary care at a high cost to taxpayers, Americans pay the highest price for prescription drugs while shouldering the majority of global research and development costs, doctors waste billions of dollars on unnecessary tests for fear of being sued, and small businesses are quickly getting priced out of the health insurance market only to join the ranks of the uninsured.

We are the most advanced country on earth, and yet there are some who still lack access to quality health care. Frankly, many of these folks live in rural areas like Wyoming. We face significant challenges, and in my mind, there is none more pressing than our rural health delivery system. Working families need access to quality, affordable, and accessible health care services. This is difficult in Wyoming, where it is not uncommon for people to go without care due to long driving distances, adverse weather conditions, or provider shortages. Maintaining strong rural health care networks not only ensures Wyomingites can access the quality care they deserve, but also drives economic development and job creation. Communities offering a viable, sustainable health care infrastructure attract and retain residents, workers, and businesses.

That is why I, along with my Senate Rural Health Caucus colleagues, worked so hard to include a $25 billion rural health package in the Medicare Modernization Act. These dollars, solely dedicated to rural health initiatives, represent the most comprehensive attempt to put rural providers on a level playing field with their urban counterparts. The Secretary of Health and Human Services must play a key role to implement these critical initiatives, and I am committed to work in a bipartisan, bicameral manner to support these programs and policies.

As Secretary of Health and Human Services, you will face many challenges in the years to come: reducing the skyrocketing cost of health care while improving quality, access, and safety; implementing the first-ever prescription drug benefit for seniors under Medicare; and finding innovative and cost-effective ways to provide health insurance coverage—including access to affordable prescription drugs. I look forward to working with you to find solutions. I wish you the best of luck as this process moves forward, and once confirmed, invite you to visit Wyoming soon to see our unique needs first-hand. Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. RON WYDEN

This may well be the most difficult time in history to tackle the job of Secretary of Health and Human Services. The challenges facing our health care system right now are enormous, and problems loom even larger for the future. David Walker, the Comptroller General of the Government Accountability Office, has already said that anticipated increases in Medicare and Medicaid obligations are quote, "unsustainable for future generations of Americans."

Skippering the Department of Health and Human Services through the rocky waters of the next few years will be no small task. It will require a pro-active, even aggressive two-pronged commitment. First, it will take a commitment to tackling the problems that can be tackled today. Then, a commitment to starting now to create a viable health care system for tomorrow—one that works for all Americans.

The outgoing Secretary of Health and Human Services recognized this, I believe. Secretary Thompson endorsed a proposal I'll want to discuss with Mr. Leavitt in the days ahead: giving the Secretary of Health and Human Services bargaining power in the Medicare prescription drug program. Senator Snowe and I had a bill in the last Congress to do that, and we will be introducing a revised version of that bill this Congress shortly. Our legislation, the Medicare Enhancement for Needed Drugs Act, or MEND, would give Medicare the same kind of leverage that private sector purchasers have to negotiate for the best prices possible for prescription drugs. It seems to me that the Medicare program should have every weapon in the arsenal to keep costs down. Bargaining power—allowing the Secretary to leverage the power of millions of seniors in the market place—can be one of the most potent of those weapons.

That's the kind of common-sense solution that can be implemented today, with bipartisan support and a will to act. I also believe there must be a long-term, bottom-up strategy to truly "fix" the American health care system. Senator Hatch and I wrote the "Health Care that Works for All Americans Act" as a fresh, radical approach to make that happen. In about a month David Walker at the Government Accountability Office will name the members of a Citizens Working Group to spearhead the effort. The Secretary of Health and Human Services will be a part of that group. They'll be charged with two things: first, to write a report to the American public about how their health care dollars are spent now. Second, to gather input from the American people, in town meetings and online about what our health care system should look like and what tough choices we're willing to make together to get a system that works for everyone. When the Working Group, including the HHS Secretary, synthesizes the response of the American people and reports to Congress, Congress is required to hold hearings on the recommendations. This is a completely new approach to health care reform that breaks with the failed traditions of the past 6 decades. Secretary Thompson has been supportive of this effort, and I hope that Mr. Leavitt will be a willing and active partner in this process this year.

The Health Care that Works for All Americans Citizens' Working Group will be one of many things on the HHS Secretary's plate. From everything I have read in the press, one task envisioned for Mr. Leavitt is to either chop Medicaid spending or turn the program into a block grant. In the same way that Senator Hatch and Senator Snowe and I have worked to find better bipartisan solutions to health policy issues, I hope Mr. Leavitt will find better bipartisan alternatives for Medicaid. It's just the plain truth that simply capping or cutting spending in Medicaid or any health program tends to exacerbate the problems—it certainly doesn't solve them.

In the 1990s efforts failed to end Medicaid's current form of financing and replace it with block grants. Most critics of block granting believe that it would destroy Medicaid program. I know that Mr. Leavitt supported the idea and was reportedly influential in working out compromises that were beneficial to governors—such as securing more control over program design.

My own State wants flexibility in Medicaid. One of our best efforts used flexibility to create the Oregon Health Plan, with its unique system of determining covered services and used savings to expand coverage. The Administration and most other States want flexibility in Medicaid as well. But as health care costs rise, flexibility cannot be allowed to become a euphemism for simply cutting the services to people in need.

Reviews of the Utah Medicaid waiver under Mr. Leavitt were mixed. The *Wall Street Journal* described it as a "novel effort," saying that Mr. Leavitt "played Robin Hood, but with a twist, taking from the poor to help others who were poor." What seems to be lacking in much of the debate about the Utah waiver is information about its real impact on the health of Medicaid patients in that State. We do not know if the lack of hospital and specialty care and reported difficulties in accessing donated free care were harmful to folks' health, or whose health may have suffered.

This example calls for better evaluations of whether different State Medicaid plans really work for everyone they're meant to serve.

How we find funds for Medicaid services in every State, and how flexibility may help those funds stretch further, are legitimate issues for debate. But that debate must rest on a commitment to making sure the programs work for people in need of access and coverage. For my part, I do not believe block grants will help the financial situation States face in providing health care to the poor.

I believe there must be better ideas for saving money and providing the basics of health care to everyone—without sacrificing people's health to do it. Let me give you a couple of examples of the kind of innovation HHS should encourage.

My State has pioneered the use of home- and community-based waivers to help the elderly receive cost-effective, quality care while staying out of expensive nursing homes. Home- and community-based care is less expensive and is frequently a better solution for many individuals. So many States now have home- and community-based programs that it may be time to update Medicaid, to help States avoid the cumbersome waiver process in this case.

Oregon has also pioneered the use of research on drug effectiveness to make sure the medicines that work are the ones being prescribed. I am proud to say that 13 States and two non-profits have collaborated to do this research at Oregon Health and Science University. This evidenced-based tool is helping providers make cost-effective decisions, and better health-care decisions as well.

These are just two examples of the kind of innovation needed to address the cost and quality of care. Innovation can come in small steps, and it certainly can come from the Secretary's office. Secretary Thompson made prevention a central issue. He recognized that obesity and diabetes were harming Americans in epidemic proportions, saw the cost to the health care system, and started reaching out to help individuals make life-saving and money-saving changes. That good work should continue.

I also believe Mr. Leavitt should focus on bringing our health care programs into the 21st century with information technology. Again, this is an issue with bipartisan support; Newt Gingrich also has made a point of advancing information technology as one of the ways to make health care more effective. I was disturbed by the lack of funding this year for HHS grants to improve the use of health information technology. I was even more disturbed when I learned that the Administration did not fight for this funding. To me, investing in health care technology is a way to purge our systems of duplications that contribute to medical errors and cost money.

It's time to look beyond the budget ax to assure access to health care for all. It's time to look for bipartisan solutions to the problems we can tackle today, and to work together for tomorrow—building a health care system that works for all Americans. It is my hope that Mr. Leavitt will commit today to being Congress' partner in both.

COMMUNICATION

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January 19, 2005

The Honorable Charles Grassley
Chair, U.S. Senate Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley:

The American Society of Health-System Pharmacists (ASHP), the 30,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems, is writing today to applaud the President's nomination of Michael O. Leavitt as the new Secretary for the Department of Health and Human Services.

The Department of Health and Human Services is a complex agency, facing significant challenges over the next few years as it works to implement the most significant change to the Medicare program since its inception in 1965 and to improve the nation's national preparedness. ASHP, which serves as the collective voice of health-system pharmacists on issues related to medication use and public health, believes that Mr. Leavitt's significant public service experience and strong leadership qualities make him the right person for the job. We look forward to working with him and encourage the committee and the Senate to confirm him quickly.

In addition, ASHP looks forward to working with you and your staff. Please feel free to contact us at any time if we can be of assistance. Kathleen Cantwell, ASHP's Director, Federal Legislative Affairs and Government Affairs Counsel can be reached via email at kcantwell@ashp.org or by phone at 301-664-8710.

Sincerely

Henri R. Manasse, Jr., Ph.D., Sc.D.
Executive Vice President and Chief Executive Officer