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THE PRESIDENT'S BUDGET PROPOSALS FOR FISCAL YEAR 2006

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

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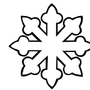

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THE PRESIDENT'S BUDGET PROPOSALS FOR FISCAL YEAR 2006

WEDNESDAY, FEBRUARY 16, 2005

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

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Lott, Snowe, Thomas, Smith, Baucus, Bingaman, Kerry, Lincoln, Wyden, and Schumer.

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

The CHAIRMAN. Welcome to Secretary Leavitt. This is his first hearing before our committee, and we appreciate the Secretary's willingness to come so quickly after his confirmation.

President Bush released his proposed budget for fiscal year 2006 a week ago. The committee has a great interest in the administration's priorities for the Department of Health and Human Services, and this hearing will try to provide the committee an opportunity to further discuss the details of the President's budget.

This budget proposes comprehensive efforts to expand access to health care for the uninsured and for making health care more affordable. We all agree with that goal. There are about 45 million Americans without health insurance, and for a Nation as fortunate as ours, that is a problem that we feel we can address, and should address.

Individuals, families, and small businesses in particular all need relief from rising health costs. The President is to be commended for putting forward these proposals on this issue.

The budget also recognizes that this is an important year for Medicare and the implementation of the Prescription Drug Act of 2003. This year, the Centers for Medicare and Medicaid Services will be completing the final work to get the new voluntary Medicare drug benefit up and running by January 1, 2006.

It is an incredible undertaking. Of course, thanks to the dedicated staff of CMS, they are entitled to recognition for the long hours and for their hard work in getting this important new benefit up and running, and doing it on time.

The Medicare Modernization Act also created the Medicare Advantage program, which will provide beneficiaries with new and better choices and enhance benefits of Medicare private plans, and hopefully that will be equal geographically across the country, in-

cluding States like Montana and Iowa where we do not have that option at this particular time.

I was very pleased to hear the President's statements of continued strong support for this new drug benefit. This Chairman also will not support re-opening the drug benefit for changes that will undermine the program, particularly because it has not been implemented yet, and how do you know it is not working until we get some experience with it?

Making changes that would deprive our Nation's seniors and individuals with disabilities the drug coverage promised by this Act would be a terrible disservice.

Surely they have waited long enough for Medicare to provide prescription drug coverage without Congress threatening to cap the program or prevent its implementation by making changes that would make the January 2006 start date unachievable.

In regards to Medicare, the President's budget proposes a number of efforts to restore the integrity of the program. I know that several of my colleagues are particularly interested in numerous changes contemplated by the budget. I anticipate there will be a number of questions about Medicaid proposals, and I look forward to hearing a thoughtful response.

I am also interested in learning more about the national outreach campaign called Cover the Kids, which is designed to get low-income children enrolled in health coverage. I think this is a very laudable effort, to get every child who is eligible for health coverage through Medicaid or SCHIP services identified and enrolled.

Additionally, pay-for-performance is a very important issue before this committee. Some would say that that is long overdue, not only from the standpoint of possible cost savings, but from the enhanced care for our people.

I believe it is time that we rewarded high-quality care. These incentives will lead to better care, fewer medical errors, and better adoption of information technology for our health care system. So, we thank you.

Now, Senator Baucus.

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

Senator BAUCUS. Thank you very much, Mr. Chairman. I thank you, Mr. Secretary. I realize your preference was to testify, I think, mid-March or early March rather than mid-February, but I want to thank you very much for changing your schedule to accommodate us. I appreciate that very much.

Before I begin, I would like to address, briefly, an issue that has been in the news a lot lately. That is, the cost estimate for the Medicare drug benefit. There has been a lot of speculation that the numbers have changed and that the estimated cost of the benefit has gone way up, and that HHS is engaged in some sort of cover-up operation again this year.

I might say, I remain deeply troubled that the administration did withhold cost estimates from Congress during negotiations on the Medicare bill. I am bothered that the CMS Chief Actuary was or-

dered to do so to keep his job. That was wrong. It is the wrong way to start the implementation of this drug bill.

But regarding the latest controversy, I do not see any. I have looked at the numbers and my staff has analyzed the new estimates. The main story is that, instead of counting 8 years of drug benefits, we are now counting 10.

Now, there might be more changes taking place behind the numbers, changes in enrollment, retiree coverage, the cost per beneficiary enrolled in Part D, and I am still looking into the causes of these shifts. But the overall cost estimate is essentially the same as the one calculated by CMS in 2003.

I appreciate the concerns of my colleagues who were surprised by the numbers and who argue that we need to revisit the 2003 drug bill, but I urge them to keep in mind that we all knew that covering prescription drugs for the Medicare population would be expensive. But we decided that it is critically important to provide that drug benefit, to provide it for the elderly and disabled, and that Medicare, without a drug benefit, made no sense.

I still have many questions and concerns about implementation of the bill. As I stated before, I remain a strong supporter of the bill as long as it is implemented as Congress intended. But for now, I believe that the controversy over the latest estimates is, at best, overblown.

Let me now turn to what I think is the most important topic of the hearing, that is, the administration's proposal to cut Medicaid by $60 billion. We all want to make Medicaid more efficient, all of us, and we all want to root out fraud and abuse in Medicaid. There is fraud and abuse probably in most government programs. Wherever it is, we want to root it out.

I am willing to consider improvements to Medicaid. I am open to talking about the need for more State flexibility, and I am open to talking about better accountability. In fact, I have a bill to help do that, that is, to shed more light on the so-called 1115 waiver process.

But I am opposed to cutting Medicaid for the sake of meeting an arbitrary budget number. I am opposed to making these cuts under the attractive, and somewhat misleading, caption of "program integrity" without a better understanding of what States are doing, whether those activities are truly abusive and what the impact these cuts will have on the people who depend upon Medicaid. To do so, I think, is just plain reckless.

Yes, 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. From 2001 to 2003, during the last recession when jobs were scarce, Medicaid added 7.5 million people to its rolls, 7.5 million who would likely be uninsured were it not for Medicaid. That says to me that Medicaid is doing its job, that is, growing to meet the need when times are tough.

Even though Medicaid costs are increasing, just as in Medicare and in the private sector, Medicaid growth is actually lower on a per-person basis. A recent study showed that Medicaid cost growth was 6.5 percent, compared with 12.5 percent—that is, double—for the private sector.

Another important factor in Medicaid spending is this: Medicaid picks up the tab for what Medicare should be covering. More than 40 percent of all Medicaid spending goes to pay for long-term care, prescription drugs, and other coverage, and cost-sharing for dual-eligibles, that is, for the elderly who are also low income. Forty percent of the costs, even though these beneficiaries only make up about 14 percent of all Medicaid enrollees. So the bottom line is, if forced to make cuts in Medicaid this year, we should all realize that it is unrealistic and misleading to say that we are simply cutting fraud and closing loopholes.

Let me reiterate that I am open to working to improve Medicaid, but we should not throw the proverbial baby out with the bath water. Medicaid is too important for too many people, and program cuts or funding caps will have a real impact on real people.

Speaking of real people, I want to thank you again, Mr. Secretary, for visiting Libby, Montana last year when you were EPA Administrator. They appreciate it in Libby. I appreciate it very much. As you well know, we still have some serious issues ahead of us, especially serious health issues, and I hope you will work with me to help improve upon what we have already achieved.

I thank you for your efforts already. Thank you for coming this morning. I look forward to your continued service. You work very hard to help our people and our country, and I thank you for those efforts.

The CHAIRMAN. Before you start, Mr. Secretary, I want to associate myself with the part of the remarks that the Ranking Member just made about the Medicare cost estimates for the future. I thank him for making that point.

It has not been made as clear as he has made it by any member of the Senate. Really, what he is saying is, we are going to compare apples with apples. All the news articles last week compared apples with oranges. So, I thank you for doing that.

Senator BAUCUS. Thank you, Mr. Chairman. I might say, Mr. Chairman, that Senator Rockefeller very much wishes he could be here. He has an obligation at the Intelligence Committee. As you know, he is Ranking Member there. He just wanted everyone to know that he really wishes he could be here, but he cannot.

The CHAIRMAN. Now, Mr. Secretary, your presentation.

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

Secretary LEAVITT. Good morning. Thank you, Mr. Chairman, Senator Baucus, and members of the committee. I want to thank you for inviting me to discuss the President's budget for 2006.

The President and I share an aggressive agenda for the upcoming year. The agenda takes us closer to becoming a Nation where health insurance is within the reach of every American, a Nation where American workers have a comparative advantage in a global economy because they are healthy and because they are productive, a Nation where health technology and information technology help improve health care and produce fewer mistakes, and help us produce better outcomes and lower cost. Fiscal year 2006, for HHS, will advance that agenda.

To advance the agenda further, the President proposes $642 billion for HHS for fiscal year 2006. That is an increase of $62 billion, or a 10-percent increase over fiscal year 2005. The discretionary portion of that budget is $67 billion, and $71 billion in program level funding.

Six hundred and forty-two billion dollars, Mr. Chairman, is a great deal of money. It is a substantial responsibility as Secretary to ensure that all of those dollars are spent effectively. The people who pay the taxes and the people who consume the services deserve no less.

Let me take a few minutes and discuss some of the budget's highlights. First, I look forward to a successful implementation of the Medicare Modernization Act, the prescription drug benefit, and the Medicare Advantage regional health plans in 2006.

With the MMA, we are helping seniors save money, improving preventative care and increasing access to doctors and medical care that they badly need, and want. Between now and January 1 of 2006, we have a lot of work to do. I give you my commitment that we will not fail.

I know there has been a great deal of discussion in the past week, and some discussion already here in the committee, about the new Medicare drug benefit.

I want to address that issue for a moment, particularly the issues that you have raised related to the inaccurate claims on the cost estimates being dramatically increased. It is simply not true, as both you and Senator Baucus have indicated.

The main reason that the 2006 budget shows a higher cost for Medicare than it did in 2005 is that they reflect different windows. Last year's projection for 2004 through 2013 looked at a period with 8 years of the prescription drug benefit. This year's project of 2006 through 2015 includes a 10-year benefit.

We should not be surprised when we look at the landscape and see a different part of the landscape when we look out a different part of the window.

Some have asserted that the estimate for MMA is now over a trillion dollars. Again, this is simply not true. The trillion dollar figure was an estimate of the gross cost. To arrive at the actual estimate, the net estimate, you subtract out hundreds of billions of dollars of Federal revenue, such as beneficiary premiums and State payments.

Focusing exclusively on gross spending levels without considering the offset savings creates a false impression and does a disservice, frankly, to the budget process and to Medicare beneficiaries.

In a little more than 10 months, almost 43 million Americans will be eligible to receive much-needed assistance with the high cost of prescription drugs. Let us put aside the differences and work together to attain the goal of ensuring that seniors and people with disabilities successfully sign up for their new benefit; we owe it to all of them.

The President and the Department are also committed to resolving the growing challenges facing Medicaid. Medicaid provides health insurance for more than 46 million Americans.

But State governments are struggling with burdensome rules and regulations and a financing system between the Federal Gov-

ernment and the States that is prone to abuse. The budget would assure an appropriate, economically responsible partnership between the Federal Government and the State governments.

As the President's budget notes, taxpayers would save $60 billion over 10 years when inappropriate Federal spending, such as that occurring through inter-governmental transfers and other loopholes, is eliminated.

If these savings are enacted through State and Federal portions, taxpayers will spend, still, nearly $5 trillion on Medicaid over the next 10 years. Spending on Medicaid will increase more than 7 percent a year for each of those years.

When spending on our most needy populations to ensure the effective use of tax dollars, we propose to build on the success of the State Children's Health Insurance Program, or SCHIP, as it is referred to, and various waiver programs.

These allow States the flexibility to construct targeted benefit packages to coordinate private insurance and to extend coverage to uninsured individuals and families that are not typically covered by Medicaid.

This is just part of the President's plan to help the approximately 45 million Americans who currently do not have health insurance policies. In addition to our efforts to improve Medicaid and SCHIP, we propose to spend more than $125.7 billion over 10 years to expand health insurance to millions of Americans.

We are working to help Americans, through tax credits, through purchasing pools, through health savings accounts. We expect to help 12 to 14 million additional people gain health insurance over the next 10 years.

We also request $2 billion—a $307 million increase from 2005—to fund community health centers. This will help us complete the President's commitment of creating 1,200 new or expanded sites to serve 6.1 million people by 2006.

All of these efforts seek basic reforms in the health system and will help us move to a more personalized, patient-centered system of medicine. To that end, the President's budget proposes an investment of $125 million to help make electronic medical records a reality.

We also work to protect the homeland. One of the areas that we made our greatest achievements in, and face our greatest challenge, is strengthening our public health infrastructure. Our proposed budget requests $4.3 billion to continue this very important work. That is an increase of almost 1,500 percent over 2001.

Including the 2006 budget, we will have spent or requested nearly $19 billion since September 11, 2001, and that investment is now showing tangible results.

To support HHS's responsibility to lead public health and medical services during major disasters and emergencies, we are also requesting $1.3 billion to support the work of CDC and the Health Resources and Services Administration to improve State and local health and hospital preparedness.

We are also requesting $600 million to strengthen the strategic national stockpile, which would provide Americans with almost immediate access to needed medicines in the event of a major health emergency.

To ensure that drugs and medical devices that Americans routinely use are safe, efficient, effective, and get to market as quickly as possible, the budget includes a request of $1.9 billion for FDA. That is an increase of $81 million over 2005.

This would also help us combat threats in our food supply. It would help us improve our means of detecting contaminated food and increase the research on ways in which to improve food security.

On Tuesday, I announced the creation of the Drug Safety Oversight Board to review the safety and the effectiveness of some drugs that may need further monitoring after they are on the market. We will cultivate a culture of openness and independence at the FDA, because there are many drugs that require additional monitoring.

The 2006 budget requests $439 million to fight influenza and to improve the access of children from low-income families to routine immunizations. Because the foundation of a society rests upon the moral values of that society, the President proposes $206 million to support abstinence education programs.

The 2006 budget expands activities to educate adolescents, and also parents, about the risks associated with early sexual activity, and provides them with the tools they need to help youth make healthy choices. We also request $150 million to help us assist victims of drug abuse through access to recovery initiatives.

Finally, the President's budget proposes an investment of $125 million to make electronic health records a reality.

In conclusion, Mr. Chairman, this is a strong, fiscally responsible budget. It comes at a challenging time for the Federal Government, with the need to further strengthen the economy and to continue to protect the homeland.

I look forward to working with Congress, with the medical community, and with Americans all across this country to implement a new Medicare law that will carry out the initiatives of the President and propose a healthier, safer, and stronger America.

Thank you.

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

The CHAIRMAN. We will take 5-minute rounds. The order is: Grassley, Baucus, Hatch, Bingaman, Wyden, Snowe, Lott, Smith, Thomas, and Lincoln.

I was not going to start with this, but you just brought it up so I will give you just a couple of opinions of mine, and you do not even need to respond. In fact, I would just as soon have you not respond, just think about them.

On FDA oversight, if that is going to work, it seems to me you are going to have to take ownership of it, and it is going to have to be outside the FDA and not within the FDA.

The second thing is, I think there needs to be some changes in existing law to make sure, if we are going to have an Office of Drug Safety, that it cannot be under the thumb of the Office of New Drugs. Now, you could say the Oversight Board is going to make sure that there is that independence, but I think that there has to be some change in machinery within FDA.

Then separate from all of that, but kind of related to it indirectly about the safety of drugs, I think we need a registry of clinical trials that is completely transparent.

Now, moving on to Medicaid. During meetings that you have had with members of the Congress, you have made it very clear that you intend to work very diligently to improve the way that the Federal and State Medicare program works, and that is a very laudable goal. It is going to take very strong leadership.

So I have two questions. What is your plan for getting this done, and how would you envision the administration, the Congress, and the governors working together to do this, if the governors are going to be included? I guess I would advocate that they be included.

I would ask you—and you may be saying you are going to do this anyway—to take very much a leadership role in trying to bring the governors, in a bipartisan way, around to helping us work this out so that money can be saved, and yet not hurt the program for people who need it.

Secretary LEAVITT. Mr. Chairman, Medicaid is a vital program in this country. As I indicated, nearly 46 million people receive health insurance. It also cares for the truest and most needy of our citizens, those who are disabled, those who are aged and disabled, and low-income children. It is a vital program.

It is, however, rigidly inflexible. It is my belief that it can be improved through providing additional flexibility so that we can use resources in a way that will provide coverage to more.

I believe we can use the resources that we are devoting to Medicaid at the State and Federal level and provide access to health care to more people, and do nothing that would threaten in any way the commitment that we have made to our neediest citizens.

I am meeting with the governors now on a basis that I hope will produce a bipartisan proposal that we can bring to Congress to do just that. I am encouraged by your commitment to this, and look forward to working with you and other members of the committee to produce needed changes and reforms.

The CHAIRMAN. Yes. A little more specific on this. States, as you know, currently have the option to cover additional services under Medicaid. If a State chooses to cover additional services, it must provide those services to most of the mandatory and optional populations.

So my question is, could you describe options States currently have regarding limiting services for optional populations and how the budget neutrality requirements work under those arrangements?

Secretary LEAVITT. Well, regrettably, Mr. Chairman, there are very few options. What has happened in most States is that, in order to meet their own budget needs and to respond to the needs of so many other programs, they have begun to eliminate entire populations of optional categories. That is not our goal.

Our goal is to cover more people, not fewer. The governors are crying out for some level of help in being able to provide coverage for more. That is the goal of, I believe, HHS, and of the President, and of the States: to cover more people, not fewer.

The CHAIRMAN. Well, that would follow into what some governors have said to me about needing more flexibility. What reforms do you hope that States would undertake if they had additional flexibility? I assume that you are suggesting additional flexibility. Is that right?

Secretary LEAVITT. Yes, I am. One is in the area of caring for those who are disabled and those who are elderly that would like to be cared for at home or in their community.

Currently, Medicaid essentially requires that they are covered in an institution, and many times that is not in the best interests of the patient, not the desire of the person being served, and it is the least efficient way to do it.

The President has proposed a New Freedom initiative that is just one example. There is money in this budget to provide for that. Under State waivers, a number of States have already begun to do this. It is something that we ought not to have to seek waivers on. It is something we ought to be able to do unilaterally. It will expand coverage to more and provide better coverage and better service.

The CHAIRMAN. What are the implications for these optional populations, in your judgment, if we simply do nothing here?

Secretary LEAVITT. If we do nothing, many will lose coverage they currently have because of the inflexibility. Our objective is to cover more. The President has put proposals forward that, in total, would allow 12 to 14 million people to be within the reach of health insurance over the next 10 years. A good piece of that would be those who are currently served by Medicaid. We have had great success in this country with SCHIP.

For SCHIP, in many cases, States chose to use Medicaid. Many other States chose to use a plan that would be patterned after either the Federal employees' or State employees' plans, and they have been able to use those plans to provide quality, basic care, and do it for more people than Medicaid. That is a very good example of the contrast.

Some States have been able to use flexibility through various means and cover more, some States have not, and they have covered fewer optional populations, and are regrettably, in some cases, threatened because of lack of flexibility.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Secretary Leavitt, in the interest of helping the people we represent, I think it is important to shed some more light on what these Medicaid cuts are really all about so that the Congress, the Senate and House, in the budget process, has a better idea of what is right and what is not right for the States, and most importantly, the people in our country.

You have identified—let us use your figure—net, $40-some billion of Medicaid cuts. That is, $60 billion, and then you subtract out the extra dollars that go to SCHIP, so the net is roughly around $40 billion. Is that correct?

Secretary LEAVITT. Would you like me to reconcile those?

Senator BAUCUS. No, not really. Thank you. I am accurate, am I not, basically?

Secretary LEAVITT. Roughly speaking.

Senator BAUCUS. Roughly speaking. Thank you.

I have a couple of concerns about all of that. Number one, in written response to the question I raised in your confirmation, you stated that CMS could only identify about $120 million in fraudulent payments in the year 2003.

These cuts are under the guise of "program integrity," under the aura of, this is wrong. Kind of an aura, if not fraud and abuse, at least, it is wrong. There is a moral label on all this. Yet, there is only $120 million identified by CMS as "fraud and abuse."

Which goes to my next point. You are asking for $40-some billion, $40 to $60 billion, whatever it is, in cuts. That is a far cry from $120 million.

Next, though, there are very few details on your proposal. We do not know what in the world this is really all about. To some degree, or to a large degree, that is not your fault, because you walked into a situation where there was a lot of uncertainty with regard to Federal Medicaid payments and inter-governmental transfers, and UPLs—upper payment limitations—and so on and so forth.

But yet, the Medicaid dollars that States have received, and the way the States have provided the matching money, have all been all right. It is legal. All States have been doing things which, up to this point, CMS said, fine. That is all right, by and large. But you are stepping in and saying, well, gee, maybe not. Maybe there needs to be some changes.

So I am asking you to be much more specific about all this. Frankly, I know this puts you in a very difficult position, because you did not ask for all the facts that you faced when you began to take over this job, but that is what we hired out for, basically, all of us.

So I would like a breakdown, on a State-by-State basis, frankly, on how these changes will affect Federal Medicaid payments to the States, because that is only fair to the States, it is only fair to the people, it is fair to us in the Congress as we are trying to figure out what the correct budget number should be on Medicaid. Would you provide that information?

Secretary LEAVITT. As best we have the ability. I think it would be helpful if I were to describe it for you, Senator. I would like to make clear that the integrity issues that we are talking about I view as separate from those that we are dealing with in the States, where I believe there are inappropriate accounting practices being used.

I put those in different categories where you have got people simply doing things that are fundamentally dishonest and meant to defraud, and those where we have got disputes over accounting.

Senator BAUCUS. Right. All right. Right.

Secretary LEAVITT. Let us talk about the States.

Senator BAUCUS. Yes.

Secretary LEAVITT. Let me put it in this context. The President's budget proposes basically three reductions and two add-backs. Two of the reductions are matters where we believe we are paying too much for medicine, and the second is that there are certain people who are beginning to give their assets away in order to qualify for Medicaid, and we do not think that is consistent with the character of the program.

The third does deal with, frankly, a fairly awkward conversation we are having with our funding partners, and that is the States.

Senator BAUCUS. That is right. That is the conversation I want to explore, the awkward one.

Secretary LEAVITT. Let me tell you why it is awkward.

Senator BAUCUS. We all know why it is awkward. We just need some transparency and some solutions here.

Secretary LEAVITT. All right. Let us assume that there are three people who live in a cul-de-sac. There is Mr. Federal and the Federal family, Mr. States and the States family, and then there is the Jones family. The Jones family has a daughter that has a serious chronic disease.

Senator BAUCUS. I see the yellow light. I know that you know there is a yellow light there, too. So, could you please use your time responsively so we can address the question I asked?

Secretary LEAVITT. Why do I not tell you the story later then to keep within the context of that 5 minutes.

Senator BAUCUS. All right.

Secretary LEAVITT. But it is a very compelling story.

Senator BAUCUS. All right. I am sure it is.

Secretary LEAVITT. Essentially what it amounts to is, the States are recycling money in a way that is not about whether or not we should provide health coverage, it is about who should pay for it. The reality is, they may have been doing it, but in most cases we have not known they are doing it, and we are still trying to figure out where they are doing it and why they are doing it. We want it to be fair and we are working with them as data comes.

Senator BAUCUS. My time has expired. I appreciate that. If I may ask the members' indulgence, very briefly. My understanding is, though, that you have looked at all this to some degree. There are a number of States where things are all right, a number of States with questions, and that is all right. There are a number of States where you are not sure, you are negotiating with. In other States, you just do not know, and so on, and so forth.

If you subtract out the first two categories of States, that awkward category is a lot of money that is supplied to a relatively fewer number of States, which can have, therefore, a greater impact.

The only fair way I see to get to the bottom of all of this is to put all of the cards out on the table. One of the cards is, what is the dollar effect going to be on each State? So, I am asking you for that information.

Secretary LEAVITT. To the extent we have it available, Senator, I will be happy to provide it.

Senator BAUCUS. You should have it. If you do not have it, that says something right off the top. If you do not want to do it because it makes your life more difficult, that says a lot, too.

I am just asking for it. You have got it. You are a huge agency. You have got lots of smart people down there. There is no doubt in my mind, if you really wanted to and if your staff really wanted to, they would provide it. So, I am asking for that information, very quickly, please.

Secretary LEAVITT. Senator, we will be responsive.

Senator BAUCUS. Thank you.

Secretary LEAVITT. I would like at some point, when we are not facing a red light, to describe for you the nature of the task so you will understand the nature of the result.

Senator BAUCUS. Well, there will be an opportunity when we go around again.

Secretary LEAVITT. Good.

Senator BAUCUS. Thank you.

The CHAIRMAN. All right.

Senator Bingaman?

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

Mr. Secretary, thank you for coming today. I wanted to just follow up on some of the discussion we have been having on Medicaid, because that is the big issue in my State.

I have noticed a pattern in the time I have been here in Washington. Every year, when the year starts, you can sort of predict a few things that are going to happen. Number one, the President is going to give a State of the Union speech. Number two, the week after that we are going to get the budget from the administration. Number three, the week after that, the States start complaining and the Federal Government starts arguing about the proposed cuts in Medicaid. That is sort of where we are today.

And I notice that you gave a speech the other day which talked about "The Seven Harmful Habits of Highly Desperate States." I think that was the title of your speech.

The National Conference of State Legislatures has come out with their concern. They call it the export of the Federal deficit to the States, mainly talking about Medicaid.

Senator Smith and I have proposed establishing a national commission, which we would have the President appoint a member, and then have Congressional leadership appoint other members, and try to get a good bipartisan group of folks who understand this and have the time to really look at it long-term and resolve some of these issues so that we could break the cycle of, every year, starting into a budget debate about who is cheating who on Medicaid.

I welcome your statement in your prepared statement that you are going to be meeting with governors and trying to resolve these things. I think that is helpful. But you are going to have a few other things to do this year, so it is not going to be possible for you to devote the enormous amount of time that I think is required to sort all of this out. It is very complicated.

I think the States have some legitimate complaints about some of the things that they complain about, and I think the Federal Government has some legitimate complaints about some of the accounting that the States have engaged in.

But I would be interested in whether you think that that kind of a commission would be helpful in this process, and if that is something you could support.

Secretary LEAVITT. Senator, to be candid with you, I think a commission, while always helpful and enlightening, would likely end up with the same dance that you have just characterized.

The facts are on the table. There are smart people in this room who are as experienced as anybody in the country on this question. The States need help. The people who are currently insured by

Medicaid whose coverage could be threatened by the lack of flexibility need help.

It is time for us to make decisions. I am very hopeful that the States, working together across party lines, could bring a proposal to this committee and we could work together to find solutions immediately. Now, there may be things that, long term, we could continue to look at that would be improvements, but there is a need for swift and early action.

Senator BINGAMAN. Well, I am not averse to swift and early action, but I do not think, frankly, that we have the time here in this committee, or perhaps that you personally have the time, although you are very knowledgeable about this issue from a State perspective, and now you obviously are going to have to be from a Federal perspective. I just think getting some folks who did not have the other demands on their time to look at this would be very helpful, so I hope you will consider that.

Let me ask another issue. One of the things that you proposed in your budget is that the Federal Government would reduce the Federal matching rate for targeted case management services to 50 percent. So the Federal Government, instead of providing the match that it otherwise provides in Medicaid—which in my State is 72 percent—it is going to say, for these targeted case management services, the Feds will provide 50 percent and the State will provide 50 percent. That has an adverse effect on my State, and all of what I see as the poorer States. It is something that concerns me.

The well-off States that already have a 50 percent or less match from the Federal Government are fine. They are held harmless on that. But a State like mine which is up against it and trying to provide these health care services will lose about $8 million next year in New Mexico because of that proposal. Again, I would urge that that be something you reconsider, if possible.

Secretary LEAVITT. Senator, that is a characteristic that is worth focusing on for a moment. There are certain areas of the accounting categories where States have become brilliant at loading costs onto categories where there has been higher-than-average reimbursement.

All we are looking for is to be able to characterize those things that are appropriately characterized as administration, and then to have the appropriate rate applied to them. This is a good example.

Many of the States have hired consultants who have become quite adept at being able to determine how to code things, how to characterize things, how to hide things in a way that will allow them to have the maximum Federal match.

Now, I am not here to suggest that they should be expected to do a lot different than that, other than the fact we ought to have the rules clarified so that we know what we are matching and that it is what we intend to match. This has become so complex, it just needs to be simplified.

Senator BAUCUS. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Secretary, I think you know, there is probably nowhere on the planet that is more interested in flexibility and waivers than

Oregon. I have been on the phone to our Medicaid directors, and they think that the proposal that you all offered essentially hits them with a double-whammy. On the one hand, they would get fewer dollars.

On the other hand, nothing is being done to change what seems to them to be bureaucratic water torture in terms of trying to get something approved. That is what they were faced with concerning the Oregon Health Plan waiver and a variety of other waivers where, literally, documents were not taken from one office to another when they wanted to have a waiver considered.

So outline for me, if you would, what proposals you have, specifically, to deal with these problems in waivers, and particularly ones where we can get to the objective you and I want, which is to stretch the dollars.

For example, one that my State Medicaid people would like is something that would say, if one State has done something innovative, it could then be put on a fast-track for other States to do it. That is something that is not allowed today. Outline for me what your suggestions would be for approaches like that.

Secretary LEAVITT. I will outline a very specific construct. One, we need to get with the governors to develop a proposal that can be brought to this committee that will meet the needs of the States, and also have integrity in the funding partnership.

I have indicated, Senator Bingaman pointed out, this is a time-consuming matter. It is an important matter for 46 million people and their health care. I am prepared to spend the time necessary to bring that, and I would hope that the committee would work with us in being able to find results.

Senator WYDEN. I am very interested in working with you, Mr. Secretary, on this and other things. I would just like to see a specific set of ideas for making sure there would be more flexibility without hurting people. I have offered one that I talked about with my State Medicaid director, and I am interested in hearing others.

I want to turn to prescription drugs because I think we are headed into treacherous waters at this point. I am someone who voted for the program. I feel very strongly about it. I have had a chance to work with Senator Baucus, Senator Grassley, and others on it.

What I am worried about is the combination of the costs going up—and we can have a debate about how much they are going up, and the like, but they have gone up—and the relatively paltry level of senior participation in the first phase.

It means that what we have is a situation where a boat load of money is going to be spent on a relatively small number of people. That is not a prescription for a program that is likely to survive. I want to work with you to make sure that a program I voted for gets back on track.

What are your suggestions this morning about how we get this back on track, and suggestions so we can all work on a bipartisan basis to do it?

Secretary LEAVITT. I think we would agree, this is a historic opportunity to expand access to prescription drugs to millions of Americans who currently do not have it. It is also a formidable task to educate and provide information to those who are eligible and to help them receive the benefit, but we will meet that task.

I would hope we could work as partners with the Congress. I would hope that, in the July and August recess, members of the House and members of the Senate will be going throughout their States and their districts, helping seniors to understand this, in partnership with HHS.

We will be using every tool available, through both private and public sector, to be able to reach the 43 million people that we believe will be eligible. It is an exciting opportunity and one that we will provide every possibility for the elderly to meet.

One thing I want to make certain of is that you are aware, and others, that we will not allow any of our elderly who are transitioning from Medicaid to Medicare to drop through the cracks.

We are going to assure that the decision is made for each of them so that they continue to have benefits, and we will do all we can to ensure that it is the decision right for them.

If a decision is made that is not, we are going to provide broad flexibility for them to change so that they have benefits and they also have the plan that is best for them.

Senator WYDEN. I think that is a constructive answer. I know my time is up. I would just say, Mr. Secretary, absent some stronger cost containment, I think it is going to be very hard to get the enrollment numbers up where you want them to be, I want them to be, and colleagues do. That is really the key to getting people signed up. That is what you hear at town hall meetings. People say—and this is a reflection of the bill Senator Snowe and I have—why are we not using the kind of cost containment that is in the private sector?

I will explore this on another round. Senator Baucus and Senator Grassley have been gracious to give me the extra time. But that is why people have been reluctant to get involved in this program, is they do not see us doing enough to contain the costs that are clobbering them every time they walk into a pharmacy. I thank my colleagues for the extra time, and I will look forward to the next round.

The CHAIRMAN. We had to skip over a few people, but I will go to Senator Smith, first.

Senator SMITH. Thank you, Mr. Chairman.

Mr. Secretary, welcome.

Secretary LEAVITT. Thank you.

Senator SMITH. I am sorry I was not at your swearing in. I was on the west coast. But I watched it on C-SPAN, and I thought that it was a very moving occasion. Your remarks were terrific.

Secretary LEAVITT. Thank you very much.

Senator SMITH. The first time you and I met, I was the president of the Oregon Senate, working on Medicaid in Oregon, known as the Oregon Health Plan, and you were the governor of Utah, testifying at one of our committees.

As Senator Wyden has talked about his conversations with our State on the President's budget proposal, I have been doing the same. They have estimated to me that the proposal, as they now interpret it, would cost the Oregon Health Plan $500 million over 10 years. That is an estimate, obviously.

But the reason Senator Bingaman and I proposed the commission was, frankly, the difficulty I have in figuring out how that

does not translate immediately to people served in the most vulnerable of circumstances. I do not know whether the votes are in the Congress at this point for the proposal.

No one has done a whip check, as far as I know, but I suspect it will be tough. Frankly, a lot of us, while we may come to the same conclusion eventually, a lot of us need to have some better understanding about where this leaves vulnerable and elderly people in my State, when the number is $500 million.

Obviously, I do not want to complicate your effort, but I am also dealing with the realities of this side of the dais. I do not know if you have any comment, further, on that.

Secretary LEAVITT. Well, Senator, I would just simply say that Medicaid does not suffer from lack of solution or information. It is a deficit of decision. We need to get to the point of making decisions on how to supply the flexibility, how to provide States with a very clear mandate on what our objective is.

I believe we can work together to do that, and hope very much that if the States are able to bring a bipartisan proposal to this committee, that we could work to move it forward. There may be long-term discussions we need to engage in. In fact, I would suggest there are.

We have some significant challenges that will take some time to resolve, but there are things that we could resolve in the near term that would have a profound impact on the citizens of Oregon in a positive way.

Senator SMITH. It is my understanding, and certainly my evaluation, and I wonder if it is yours as well, that Oregon is not among the States that is engaging in these inter-governmental transfers and scamming the Medicaid system. Is that your understanding?

Secretary LEAVITT. Senator, I am very happy to have that conversation directly with you. I have got a list of those we are working feverishly with, and I would be happy to look at that list in a moment, if you would like. But let me just say, we are working very constructively with States.

In most cases, we are able to reach agreement on what is an appropriate practice and what is not. In many cases, what we are working most strenuously on is how to work our way back to what is appropriate, and we are working to provide the time necessary. This is not about blame, it is about restoring integrity to the funding partnership, and I believe we will get there with nearly every State.

Senator SMITH. Let me express appreciation to the President and to you, Mr. Secretary, publicly. While many things have been cut out, what was included was $11.5 million for youth suicide prevention. I am very grateful for that and for the President's support from the beginning to this moment, as reflected in his budget.

I know this runs counter to the need, but full funding for that program in its second year would be $27 million, and I hope you will not mind if I push really hard to get that.

Secretary LEAVITT. No one would question the intent of that.

Senator SMITH. It was interesting, on the issue of anti-depressant drugs, to follow this Botox—not Botox. The Zoloft defense in a recent murder trial. It failed. Yet, in conversations that I have had with Secretary Thompson before, it was very clear to him, and

I think others at the FDA, that some of these anti-depressant drugs may really have some serious, life-threatening consequences.

Obviously, there is a lot more good being done by them than harm, but it seemed to me like he was putting the brakes on these drugs to at least get more answers. Countries like England have actually either labeled them or taken them away because there is apparently some side effect.

In that light, I want to commend you for the Drug Safety Oversight Board that you announced. I think this has to go on. But I wonder if that does not suggest that there ought to be a more rigorous approval process in the beginning.

Secretary LEAVITT. One thing with certainty it means is that we need to ratchet up our monitoring of drugs after approval. We have the technology tools to do it. We have the capacity to capture millions of data points and we have been, up to this point, more passive than we must be in the future.

Senator SMITH. Well, I certainly want to encourage that. Mr. Chairman, my reference to Botox was not a Freudian slip. I have never used Botox. [Laughter.] My time is up. Thank you.

Senator BAUCUS. I think Senator Thomas is next.

The CHAIRMAN. Senator Snowe was next, but she is willing to let Senator Thomas go ahead of her.

So, Senator Thomas, proceed.

Senator THOMAS. Wonderful. Thank you so much.

Welcome, Mr. Secretary. I am delighted to have you here.

During your confirmation process, you indicated that rural health care issues would be a top priority for the Department. As you know, many of us here have worked hard with the Rural Health Coalition, as well as Finance, to include the rural equity package in the Medicare bill.

This really was the first comprehensive rural and frontier providers' effort that we had made. The measure has gone a long way towards the gap in payment and was not intended to be the sole revenue source.

The equity provisions do not address some fairly significant issues: rural patients diagnosed with more chronic conditions are less likely to have prescription drug coverage; rural areas' proportionately higher rate of uninsured and under-insured.

So, I guess I am a little disappointed to see significant cuts in the Health Resources and Service Administration budget, eliminating or drastically reducing the Rural Health Flexibility grant program, the Small Hospital Improvement Program, the Rural Healthcare Services Outreach, and Rural Access to Emergency Devices grants.

Would you respond to that?

Secretary LEAVITT. First off, I want to make clear that I personally, coming from a rural State, understand the importance of this. I know that the President's commitment is real. The budget does recategorize a number of different provisions.

Of course, it includes ways of being able to approach rural health care from a number of different angles. For example, the community health centers are, in large measure, located in rural areas, particularly those with significant unmet needs.

I think I would be better off being able to provide you with the data in writing than I can today in specific off the top of my head, and I will do so.

Senator THOMAS. All right. I appreciate that. As you well know from your State, we have a different system. We have to have a system, because each town and each facility does not have all these kinds of services. I think we have one community center in Wyoming, as a matter of fact. So, I would be grateful if you could do that.

Secretary LEAVITT. I do want to acknowledge, Senator, the leadership that you have provided, along with Chairman Grassley, in being able to include $25 billion over the last 10 years for rural medicine, $109 million in this budget. So, I will give you more information, but I did want to acknowledge that.

Senator THOMAS. That has been very, very helpful in terms of making some equity in the kinds of payments that are made, and so on. So, thank you. That is all I have.

[The information appears in the appendix.]

The CHAIRMAN. Thank you.

Now, Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

I welcome Governor Leavitt to the committee. Again, I am sorry I was not here for your testimony, but I have been shuttling back and forth between hearings in two committees.

Let me just get back to the question of the rising prescription drug costs. I know that you mentioned, in response to one of the questions, I think, posed by Senator Wyden, that obviously the window changed in terms of the 10-year projection.

But on the other hand, even within the original estimate and the original window starting in 2006, the cost was still rising to $557 billion over that time frame.

So, obviously we still have a problem. Irrespective of changing the windows, it was magnified by doing so and having a full 10-year projection instead of including just the phase-in period of 2 years leading up to 2006.

So I think that that gets back to the crux of the issue of what we are going to do to address these costs, and the need to have negotiating authority. I do think that that is a critical instrument.

It is not the sole answer to the problem, obviously, but it is a critical tool to addressing and grappling with rising costs of prescription drugs, particularly those that are sole-source drugs and have no competition, and also in the fall-back programs in which there may be numerous areas of the country where they will have a fall-back program, and it is going to be all the more important for you to have that authority and to use it in certain circumstances and require it. That is the legislation that I have introduced with Senator Wyden.

Secretary LEAVITT. Senator, I may be responding to different time periods still, but I would like to clarify that, for the period of 2004 through 2013, the estimate last year was $510 billion, this year is $517 billion, which is well below 1 percent fluctuation.

Senator SNOWE. But that estimate came out last late fall. It was not the original estimate when we were considering that legislation. It was not the CBO estimate.

Secretary LEAVITT. I understand there are some differences, and much discussion has gone into reconciling those.

Senator SNOWE. Right.

Secretary LEAVITT. With respect to, how do we provide the best opportunity for the lowest possible cost, it is the position of the administration—and I share that position—that the best way to do it is to provide a rigorous and active market where those who are manufacturing the drugs are negotiating directly with multiple competitors. That will, in fact, provide the most competitive market. This system is based on that.

I feel more optimistic every day that we will be successful in having multiple providers of multiple drugs in every category, and that it will be a rigorous, competitive marketplace that will produce the lowest possible cost.

Senator SNOWE. I know you have been in your position for a short period of time, but have you had any opportunity, Mr. Secretary, to consider some of the factors that might be driving these costs? Because, again, hopefully there will be multiple competitive drugs on the market and that it will be a very competitive system throughout the country.

But, again, I do believe that this negotiating authority is going to be essential and instrumental, because it will also be the leverage that will be required in making sure that that comes to pass in achieving the lowest possible prices and a fair system for those who do rely on a fall-back system, because there are not many options in given areas. That may be true in my State, for example, and in many of the rural areas across this country.

Secretary LEAVITT. Again, I feel more optimistic every day that we are going to have a robust, competitive market in every region of the country. As you have pointed out, to the extent that we had less than two providers, we would have a fall-back.

Yesterday, Medco committed that they were going to play a national role. That means we are halfway there to having at least two in every market. I think we will have more. I think it will be a robust, competitive market where not only will we have multiple providers, but they will be required to have multiple alternatives, and that is the formula for the lowest possible cost.

Senator SNOWE. Have you had a chance to assess these factors at all, a preview into why they are driving up the costs of the estimates?

Secretary LEAVITT. Actually, I have just begun to understand what the factors are that go into the estimates. I am not able to enumerate them today to you, but undoubtedly they are a big issue for me, as they are for the Congress.

Senator SNOWE. All right.

On the question of Medicaid, and I know you have had numerous questions, but I am supporting the legislation that has been introduced by Senator Smith and Senator Bingaman, because I do think that we cannot afford to take precipitous action when it comes to the issue of Medicaid. I mean, it is an over-arching issue.

It serves needy populations throughout the country, and any kinds of changes are going to magnify, I think, and exacerbate the existing problems, particularly with those who do not have access

to health insurance and the growing uninsured population in America.

I know you mentioned the fact in a speech last week that optional populations may not need such a comprehensive solution because most of them are healthy people, but many of these people do not have access to health insurance, and that is obviously one of the greatest problems that we are facing in America in our domestic agenda, the growing population and the greater needs for those who are uninsured.

Capping the program, I do not think, can be a substitute for flexibility. I am concerned about that, because ultimately it could be a euphemism for reducing the program and providing support to the neediest populations. Obviously, we do not have the specifics of any proposal. I assume it is going to be forthcoming.

Secretary LEAVITT. We are working with the States to come up with a bipartisan proposal that we could bring to this committee. I would also like to make clear that we are not proposing any block grants, nor are we imposing any involuntary limits on optional populations.

What is occurring, however, is that States, because of practical limits they have, have begun to reduce coverage or to eliminate coverage to optional beneficiaries, and we want to avoid that. Our objective is to have more covered, to have health insurance within the reach of all of those populations.

Senator SNOWE. Can you expand the populations without expanding Federal support?

Secretary LEAVITT. Senator, I would point to my own experience as a governor. We were among about 30 States who chose, when SCHIP was made available, not to use Medicaid, but to use a benefit program that was very similar to the one that my own children had while I was governor.

We were able to provide coverage to 35 percent more people by providing the same quality care that my children received while I was governor to them. That is just indicative of what I believe States can do.

In your area, for example, in the neighboring States of Vermont and New Hampshire, one has used home and community care and flexibility they received under waiver for the elderly and disabled population, dramatically different than in other States close by who do not.

So, yes, we can provide coverage to more and we can provide high-quality, basic care that is similar to what State employees have, Federal employees, or the best HMO that is in their area. We can provide coverage for more people with existing resources.

Senator SNOWE. Thank you, Mr. Secretary.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for joining us again. I feel strongly, as you had stated earlier, that Medicaid should remain our Nation's safety net and not be used as a de facto long-term care program for our country.

But we have to acknowledge that, in many ways, that is a lot of what it has become nationally and in our States. Nationwide, 60 percent of the people in long-term care are paid for by Medicaid.

In Arkansas, my home State, 80 percent of those in long-term care are paid for by Medicaid. It is a tremendous part of what we are spending those dollars on.

The President's budget proposes to change the rules regarding the nominal assets on individuals that they can retain in order to qualify for the Medicaid long-term care services. As you know, the current law requires individuals applying for that Medicaid long-term care to divest all but a minimum level of assets before becoming eligible.

If the applicants transfer their assets at a below-market value to avoid these requirements, the Medicaid rules hold them subject to delays in eligibility. The budget process that the President has provided us proposes tightening up these existing rules.

I guess my question is, I would like to know how you plan to implement this change in asset transfer. Can you provide us with some more details, hopefully today, and then in written answers?

How do you expect it will impact the seniors trying to enter nursing homes, those that are in nursing homes, and the nursing homes themselves? I am hoping that you will ensure that it will not result in a lot of seniors with nowhere to go.

Secretary LEAVITT. Senator, our objective is to care for the maximum number, and to cover, frankly, all who are in the categories of the mandatory populations, and then to expand beyond that as far as the States can. We are working with the States to create a set of guidelines and a specific proposal.

Senator LINCOLN. Do you have that proposal where you implement the changes in the asset transfers?

Secretary LEAVITT. We are actually working right now with the States to develop a proposal that will be workable from their standpoint. This is a proposal—a request, actually—that is being made by the States, as well as the national government.

Our purpose is to cover those who are legitimately within the category of the mandatory populations, but to stop a migration through a practice where people give their assets to their children, or their children have them so as to protect their assets so they can qualify for Medicaid.

Senator LINCOLN. But you do not have a policy design already for the implementation of the change in that asset transfer yet.

Secretary LEAVITT. That exists today. There are specific tightenings that need to be made, and we can provide those to you.

Senator LINCOLN. All right. So you will provide us the tightenings that you are reflecting in the budget numbers?

Secretary LEAVITT. That is correct.

Senator LINCOLN. All right. Great.

Well, the next thing is, obviously we want to be able to make sure that as many people as possible can provide for that long-term care.

I have been working with Senator Grassley to create both tax credits for caregivers and individuals faced with the immediate expense of long-term care, and also providing tax deductions to help consumers pay for their long-term care insurance premiums for policies, to meet stronger consumer protection standards, and just making sure that more people are prepared.

Last year, the President's budget included a proposal to provide an above-the-line deduction for long-term care insurance. Why did the administration omit this proposal from the President's budget this year?

Secretary LEAVITT. Senator, I am not actually able to respond to that. I do not know. As you know, I have been here only 21 days. I have been working with the larger-themed issues. But I can get back to you with an answer.

Senator LINCOLN. I hope you would. I do think this is a critical issue. If we are going to encourage people to move forward and provide for their own long-term care in the future, I think we have to make sure the incentives are there. I hope that you will come back to us and let us know if there is a specific reason that the President had that in previous budgets, and now has eliminated it.

Secretary LEAVITT. We will respond to that.

Senator LINCOLN. That is a critical something.

[The information appears in the appendix.]

Senator LINCOLN. One of the concerns I think many of us have is, we know that Medicaid is a huge cost to the Federal Government and to the State governments, and that, hopefully, as we look at ways that we can make it more efficient and more effective, that we can do that, but that we will make those policy decisions based on policy decisions and not budgetary decisions.

So, I guess much of my concern is that, in some of the budget actions that we have seen in the President's budget, we are actually seeing policy actions decided or maintained through budgetary decisions. I think there is a lot of concern there.

I guess one of them is the health care provider tax. You have talked a little bit about the health care provider tax which was passed by Congress for States to be able to raise more money to draw greater amounts of Federal dollars.

Phasing out that provider tax, saying they are fraudulent even though they are completely legal, I think, is one of those issues. If we have a problem with that policy, I think we should address it as a policy concern. I guess my question is, how fast do you plan to take away the money from the States?

Secretary LEAVITT. Senator, there are three provisions of the President's proposal, two of which we are in, I think, great harmony with the States on. One is paying less for prescription drugs.

The second is the matter we just talked about, tightening the provisions on who can give their assets away and qualify. The third, is just an awkward conversation we are having with our funding partners about who pays what.

It is not about not providing benefits. It is about, who pays for what portion? The provider tax was not something created by Congress. It is a means which many States have begun to use to come up with their share of the money.

Senator LINCOLN. But it is perfectly legal.

Secretary LEAVITT. Some of it is perfectly legal, some of it is perfectly appropriate. What is not appropriate, however, is when they give money to the providers and then they take it back as a means of getting the Federal Government to pay more and for them to pay less. That is not consistent with our partnership.

Now, if the money is going to the provider, not only is it all right, we will put up our share. That is what we are trying to do: to get money to providers to care for people.

But if, in another transaction, they are requiring the provider to give it back to them and then raising the price so that we are paying more and they are paying less, I do not think any of us feel good about that.

Senator LINCOLN. Well, I am not saying that it is a perfect system, nor does it need to be revised or looked at. My concern is just setting a budget number on it as opposed to discussing the policy of it. I think discussing the policy in these venues is a much more appropriate way to approach it.

The CHAIRMAN. Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I appreciate your being here today. This is obviously an area of enormous interest. I heard some of the comments back in my office from the Ranking Member and others with respect to the specific amounts per State, and I know you are going to pursue that.

But let me just say that I have a lot of difficulty with this budget, and with the proposal, for a lot of different reasons. You have been a governor. You have balanced budgets. You know what honest budgeting is all about. I regret that the overall budget that is in front of us, I think, is significantly a shell game. Many people have pointed that out in different ways.

But in the 22 years I have been here, it is one of the most inaccurate, almost dishonest, budgets that I have seen. It does not cover the war in Iraq or Afghanistan. It does not cover Social Security. It does not reflect the permanency of the tax cuts, which is almost $1.6 trillion. I mean, none of this is in the budget. There is almost $5 trillion of proposals that you guys are fighting for that are not in the budget. So, there is a different set of books. A totally different set of books.

It is sort of Enron-style accounting; you have a set of books over here for what you really want to do, and then something you present to us. I do not know why you did not just present us something that said you balanced the budget, because it would have been, in effect, the same thing.

Now, you have a proposal that you are calling "Cover the Kids," implication, we are going to cover the kids in America. There are 11 million children without health insurance in America. Correct?

Secretary LEAVITT. The exact number, Senator, is not something that I am able to give you.

Senator KERRY. It is about 11 million. There are about 9 million under the age of 19, are you aware of that, who have no health insurance?

Secretary LEAVITT. Senator, I am aware that there are, in fact, somewhere between 35 and 45 million people in this country who do not have access to health care.

Senator KERRY. Well, I am talking about kids. Your program is called "Cover the Kids." How many kids do you cover?

Secretary LEAVITT. Well, we are proposing an additional $10 billion.

Senator KERRY. You are proposing an additional $10 billion based on your first proposal that puts $1 billion into outreach. Correct?

Secretary LEAVITT. Senator, the administration is putting forward a proposal, over the next 10 years, that would spend $125.7 billion——

Senator KERRY. You are not answering my question, Mr. Secretary.

Secretary LEAVITT [continuing]. To provide coverage to an additional 12 to 14 million people in America.

Senator KERRY. Mr. Secretary, that is not correct, and I will tell you why it is not correct. Seventy billion dollars of that $142 billion is in tax credits, and it has a $1,000 tax credit level that is not going to apply to most people that do not have health insurance. It is just not correct. That is part of the game that I am talking about.

It is $70 billion that probably will not be spent. But I want to come back to the $1 billion. You have a proposal to spend $1 billion for outreach. Is that correct?

Secretary LEAVITT. One billion for outreach and 10 billion to pay for the children that are currently not covered and fall within that 35 to 45 million people who have no coverage.

Senator KERRY. Only if the outreach is successful. Correct?

Secretary LEAVITT. Well, we have been very successful on outreach, when you consider that 5.6 million children are now covered under SCHIP who were not a very few years ago.

Senator KERRY. Well, we started that and we have been pushing that. But the fact is, there are 7 million kids eligible who are not covered because we have not gotten the outreach. This administration allowed $1 billion to lapse last October which was fixed for outreach. It just let it lapse.

Now, the history of outreach, in your own State included, is that when you are cutting—you are cutting $60 billion in Medicaid, are you not?

Secretary LEAVITT. We are not. Over a 10-year period, we are not cutting any services to any people with those dollars. We are paying for prescription drugs at a lower rate.

Senator KERRY. But you are cutting $60 billion that currently goes to Medicaid, to the States. The governors are screaming about it. You are cutting $60 billion. Correct?

Secretary LEAVITT. Senator, we are simply having a conversation with the States about who is paying it. This is not about reducing services, it is a question of who is paying it. We believe the States should be paying, they believe that we should be paying. It is a dispute between partners.

It is one that we believe we are right on, and one that we believe will not result in any person receiving lower coverage if we are able to return integrity to the funding partnership.

Senator KERRY. Well, you used the word "integrity" with respect to what the States are doing today. The States are doing today what they are doing. It is allowed under the law. You call it fraud and abuse, but it is allowed under the law.

It is not actually fraud, it is just, they are gaming the system. I agree with you, we ought to change that. We should not allow them to game it. But they are gaming it under the law.

Secretary LEAVITT. Well, that is a dispute. We have been working with your own State and have come to a solution that is amenable to the State and will allow them to provide continued funding in the way that they would choose to. But we needed some changes, and Governor Romney was willing to do it.

Senator KERRY. I am for some changes, but you are sort of avoiding what I am really getting at here, Governor, which is that when you are cutting $60 billion and the money that you are holding out, $142 billion total, $70 billion of which, incidentally, is in this tax credit, there are very few people who are going to be able to take advantage of that who are in the population that are needy, so you are talking a fictionalized shell game.

It takes money away from the people who are currently needy and getting it and providing a very high deductible incentive to people who can only participate if they can save money in a savings account, and the population we are trying to reach, we are not necessarily going to reach.

Now, let me give you the documentation for that. I have been talking to governors around the country, and they are finding it already very hard to go out and enroll kids. But even in your own State, you may recall, in 1996 we set up a special $500 million fund to help States do outreach, and we paid 90 cents of every dollar of it. All we required was 10 cents from a State to go do something. You remember what happened?

Secretary LEAVITT. Well, Senator, I am very pleased to defend what happened in my State, because what happened in my State, is that we were able to cover 27,000 children, 35 percent more than if we had used Medicaid as a means of doing it.

We were able to take those dollars, innovate, and cover 35 percent more because we had the flexibility, which is exactly what the governors are asking for: give us the flexibility and we can cover more children.

Senator KERRY. I am all for flexibility. We need flexibility. I want flexibility. I want as much flexibility as possible. But I want a flexibility that actually empowers people to be able to do it.

I mean, the fact is, in that experience of outreach, 17 States had used no more than 10 percent of the 90 cents on the dollar that had been offered them. Only four claimed more than 50 percent. They did not do the outreach, which is part of the problem with the whole program today. There are barriers to the outreach, and you do not do anything to remove any of those barriers here.

In fact, your State of Utah did not even use the money until about 4 years down the road. I think you were allotted $4 million in Utah for outreach under that fund. You only needed to spend $400,000 in State funds to get $4 million in return, and you said no thanks.

Secretary LEAVITT. Senator, we exceeded the number of people who could be covered.

The CHAIRMAN. Mr. Secretary, just a minute. I want to be flexible with Senator Kerry. When the red light goes on, we let people

finish their question. So I assume you finished your question now, and then you take the time to answer the question.

Secretary LEAVITT. Senator, we, on SCHIP, enrolled 35 percent more children than we would have had we used Medicaid. If we did not spend all of the money recruiting them, it is because we enrolled all of those who were allowed under the program without having to spend the money. I do not think any of us would have us spend money we did not need to in order to max the program.

Senator KERRY. Actually, Governor, I am not allowed to respond now because of the red light, but I will come back in the next question and set the record straight on that.

The CHAIRMAN. Mr. Secretary, in 2000, Congress passed the Energy Employees Occupation Illness Compensation Program to provide compensation to Department of Energy employees who were unknowingly exposed to radiation while assembling our Nation's nuclear weapons during the Cold War.

When Congress passed the law, we knew some sites would not have adequate records to reconstruct the workers' exposure to radiation. To deal with this problem, claimants are allowed to petition you, as Secretary, for eligibility as what is called a "special cohort."

Inclusion in the cohort would mean automatic compensation for workers with one of the 22 specified cancers. Last week, the National Institute of Occupational Safety and Health and the Advisory Board for Radiation and Worker Health recommended that workers at the Iowa Army Ammunition plant in Burlington, Iowa be added to the special exposure cohort.

Have you been made aware of this special exposure cohort recommendation for Iowa, and have you had an opportunity to look into it? This petition is now, or soon will be, before you for consideration.

Congress provided your office with 30 days to render a determination once you received the opinion of the advisory board. I understand you have been in your position just a few weeks, but would your office be able to work within that deadline?

Secretary LEAVITT. Senator, I am aware of this situation. I want to express appreciation to you, and also to Senator Bond, who have very persistently pursued, on behalf of these particular claimants, a remedy.

I am aware that the board has voted. I have not yet received notice of it formally. As I do, we will act as quickly as possible to meet the obligations of the law, and will be pleased to keep you informed of that action.

The CHAIRMAN. And not that you would be aware of this letter, but on February 11 I shared with you in a letter my support for the workers' petition, and I would hope that you would read my letter and take my position seriously. These workers, or in many cases survivors, have been seeking compensation for their cancer for nearly 5 years.

That is the end of my round. Go ahead.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, I have three questions/points. I will mention each of the three and ask you to take them together and respond to them.

Number one, I again thank you, and I will forever thank you, for going to Libby, Montana. There is such a problem up there, as you well know, with asbestos-related deaths in Libby. The vermiculite plant up there emits particularly pernicious type asbestos, Tremulite, which is the most dangerous, the worst. It has a long latency. You cannot see it as well on X-rays. It is terrible.

There have been over 200 deaths already in little Libby, Montana, related to all this. We are trying to put together sort of a research clinic to get at the problems and help people who have asbestos-related disease.

As I mentioned, there are 200 sites all around the country. I think you met with Dean Forbes, the dean of the pharmacy school in Montana, to talk about what we are trying to do, and I would strongly urge you to see if you could help out in your Department.

Second, I see that the administration is proposing caps on services. Also, you are suggesting budget neutrality. My question is, that, in effect, looks like you are block-granting or putting caps in the budget proposal on Medicaid spending. Is that accurate?

Secretary LEAVITT. I believe you would be referring to the fact that, in our 1115 waiver process, we almost always involve some commitment for budget neutrality, and often include caps that are basically proposed by the States, as well as the Federal Government.

Senator BAUCUS. I am violating my rule of three questions and then the response. But, in effect, are the caps proposed that are greater than, or more in the nature of caps than current law and practice?

The third question has to do with non-interference. In letters back and forth between Senators and CBO, essentially CBO is saying if the non-interference provision in the Medicare drug benefit provision were dropped and eliminated, CBO said there would be little, if any, potential savings from negotiations involving those single-source drugs. Little or no savings.

Then that issue was refined. What if you were given the authority to negotiate drug prices? The answer to that is, well, with respect to single-source drugs that did not face competition from therapeutic alternatives, there could be some savings. The net effect is, according to CBO, not a lot of savings.

So my question is, if that is the case, do you agree with that analysis? If you do agree with that analysis, why? If you do not, why? If you do, what do you say to those Senators who think it is a good idea to drop the non-interference language, to delete it and/or put in some authority in subsequent legislation to allow Uncle Sam to negotiate? Those are the three questions.

Secretary LEAVITT. Question one. Libby. I am glad I went.

Senator BAUCUS. We are, too.

Secretary LEAVITT. I might indicate that I had a fascinating conversation with former Governor Roscoe, who grew up in Libby.

Senator BAUCUS. Played on the basketball team.

Secretary LEAVITT. He told me about spending time playing as a child on piles of vermiculite and the long-term, potentially devastating health effects. I am glad I had a chance to see it firsthand. I was aware of the proposal in the clinic, and I am glad you reminded me of it. Thank you.

With respect to caps, the administration's proposal includes no block grants and no involuntary caps on Medicaid. Now, caps have been part of Medicaid since the beginning, on 1115 waivers, for example, and the fact that optional populations are, in fact, optional. That is the problem.

Currently, the only remedy that States have, given the demands that the program has begun to place on them financially, is to abandon optional groups, and we want to avoid that. We want to be able to provide access to broader numbers of people as opposed to having the limits that are placed because of the rigid inflexibility of the current program.

With respect to your last question, again, I want to restate that it is our belief that the best way to provide the lowest possible prescription drug costs will be to have multiple providers for multiple drugs. I will acknowledge, again, that our actuary has reaffirmed that no savings would occur if non-interference was dropped.

I've got the red light. I will stop.

The CHAIRMAN. Well, did you answer his questions?

Secretary LEAVITT. I did.

The CHAIRMAN. Then we move on.

Senator BAUCUS. I do not think he did. I am sorry. No. That is all right.

The CHAIRMAN. No. Let me make this clear here or Senator Kerry will think I am being prejudiced against him. If the member starts the question before the red light goes on, the member can finish the question and then you have an opportunity to give a full answer to that question. So, proceed.

Senator BAUCUS. I am fine, Mr. Chairman.

Secretary LEAVITT. I have concluded.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you, Mr. Chairman.

I wanted to just take a minute here and ask about another part of your responsibility which gets very little attention here in the halls of Congress, but it deserves some, and that is the Indian Health Service.

Two big problems that I wanted to get your reaction to. One is, this is seriously underfunded. In my opinion, it is seriously underfunded. The things we have been generally talking about here at the hearing and that you have responsibility for are entitlement programs.

You indicated Medicaid is going up by 7 percent a year. The budget you have given us proposes a 2 percent increase for Indian Health Service. The budget documents behind that say that Indian Health Service is going to have to serve 29,000 more people next year than it does this year.

So you have not only the increasing cost of health care, but you have increasing numbers of people demanding service and the budget never keeps up. That is partly because this is a discretionary part of the budget. It is not an entitlement. Therefore, it is easy to save money in this area. Unfortunately, that has been done each year.

So, that is one problem, and I would be interested in any thoughts you have as to how we break out of that and start pro-

viding adequate funds. One statistic. The Indian Health Service per capita funding is $1,914 for the people who are eligible for those services. That is about half of what we spend on Federal prisoners. That is not, to my mind, a good statistic.

The other part which I would like you to comment on is urban Indian health care. About half of the Native American Indian population in this country lives in urban areas today. I am informed that 1 percent of IHS funding goes to provide services in those areas.

In my State, of course—I know I have written to you about this and spoken to you about it—the Albuquerque Indian Health Center tries to provide services to urban Indians. They have had to announce that they are no longer able to provide urgent care because of inadequate funds, and they cannot keep the staff, so they are RIFing or cutting their staff and terminating those services.

So, there are the two issues. One, is overall IHS funding. The other is, how do we get adequate funds to provide services to urban Indians out of the mix of funding that is there? What do we do about circumstances like this clinic having to terminate services in Albuquerque for urgent care?

Secretary LEAVITT. Senator, I have, somewhere in my memory, information on the situation in Albuquerque. They are not fresh enough with me that I would attempt to recount them. I have been made aware, and will try to deal with you directly on that matter.

I would, however, like to just offer as a reminder that many of those served who are Native American populations are served by Medicaid and served by other health care programs, many of whom use the clinics. That equation, overall, ought to be considered as we have mutual concern about the health of the clinics, as well as the people.

Senator BINGAMAN. And do you have any thoughts on the urban part of it? What I am told is that tribes sign these 638 contracts which say they will provide services directly to their members.

That then results in the funds that would otherwise go to support things like this Albuquerque Indian Health Center. Those funds get taken away to provide services out on a reservation, whereas, the Indians are still in town. I do not know if that is the circumstance, but that is what I have been told. Do you have anybody who is looking at that?

Secretary LEAVITT. I will shortly.

Senator BINGAMAN. Very good. I would appreciate that.

Secretary LEAVITT. I will have to find out more about that and get back to you. But let me just say, generally speaking, that the Indian Health Service's clinical services, their budget includes allowances for inflation and for population growth. The budget proposal of $128 million is a 5 percent increase. We should get together and reconcile the differences.

Senator BINGAMAN. Where does the 2 percent come from? You are not familiar with the 2 percent increase that I was advised was in your budget for IHS?

Secretary LEAVITT. I am not familiar with that. We should get together and reconcile those two numbers, because that is not consistent with what I understand.

Senator BINGAMAN. But even at the 5 percent, it is not covering the increased cost of health care as we see it reflected elsewhere in the private sector, in Medicaid, or in Medicare.

Secretary LEAVITT. The base of my knowledge on the details of this is not sufficient to respond to your question. I will speculate, however, that one of the revenue items that will go into that accounting will be uses of Medicaid, and it would not be reflected in the base budget of Indian Health Service.

So, I would like to get with you and say, let us examine the health of it overall. I think there may be several different accounts that would bear on the question.

Senator BINGAMAN. Thank you very much.

The CHAIRMAN. Now we go to Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Secretary, I want to go through where I think we are on prescription drug cost containment, and do it very specifically.

Here we are in February of 2005. We have this program starting in 2006. By my analysis, we are going to spend a ton of money, as of today, on a pretty small number of people, which certainly is going to be attacked in a lot of quarters.

You have made the recommendation—a sensible one—that members of Congress and everybody else go out in July and August and try to make the case for the program and get people signed up, which I am happy to do as somebody who voted for the program.

What happens when you try to make that case is you get razzed pretty hard because people say, what is going to be done to contain the costs? I make the argument that you have made.

Well, there are going to be all these plans out there that are going to contain the costs, and that will be a source for cost containment. People say, what happens if that is not the case? What happens if we do not have all of the plans? And this gets to my question.

Your predecessor, Tommy Thompson, said at that point it would be very helpful to have the authority to step in to be able to respond to people who are up in arms about costs. That is what he said, that he wished, in his last press conference, he had the authority, in the bipartisan, Snowe, Wyden, McCain, et al., legislation.

Why do you disagree with Secretary Thompson's thinking that it would be helpful to, in effect, have that as just a tool in your quiver? In other words, nobody is going to rush out and do some one-size-fits-all, run-from-Washington, cost-containment approach.

But it could be an awfully good tool so that we could respond this summer to people who would say, where there are not the plans, where there is not the competition, we have some certainty that your government is going to try to stand up for you on costs. Why do you disagree with that thinking that Secretary Thompson had?

Secretary LEAVITT. I have not talked directly with Secretary Thompson, so I am not sure what was in his mind.

Senator WYDEN. He called for the authority.

Secretary LEAVITT. I have read those accounts.

Senator WYDEN. I would like to know specifically. This is important to me because I want to work with you. Why do you disagree with the Secretary, so that those of us who voted for this program

and feel passionately about it—I dreamed about doing this since I was director of the Grey Panthers. I want this to work.

But unless you give us some tools to respond to people on this cost-containment issue, I do not think they are going to sign up. I do not want to see that happen. Why do you disagree with Secretary Thompson?

Secretary LEAVITT. Senator, I believe that we will have a robust marketplace in virtually every part of this country, where seniors will be presented with alternatives and options with well-qualified drug plans that will be competing for their business, and that, in fact, that will provide the best environment for low-cost prescription drugs for millions of seniors.

Now, that is also added to by an analysis of the chief actuary for CMS, who indicates in a letter that they have considered the issue and believe that direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of a greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces.

We fundamentally believe that the best way to provide markets is a robust set of choices for seniors, and then to make those known to seniors, and that the market will drive those prescription drugs to the lowest possible level.

Senator WYDEN. I still think I would like an answer as to why you disagree with your predecessor, because I want what you are talking about. That is certainly my preference. That was certainly Secretary Thompson's preference. The question is, what happens when we do not have that theoretically ideal kind of world? I am going to work with you to get people signed up. I hope you will meet us halfway on this cost-containment question, because I think you are going to find, if there is much more bad news about this program, and we took a lot of hits last week, it is going to be very hard to do what you are talking about, what I am talking about. You have got Senators on this committee who voted for the program, want it to work.

But the Thompson quote, in particular, comes up constantly at town meetings. When we go out to sign people up, they say, my God, even the previous Republican Secretary of Health and Human Services said there ought to be something else if the theories do not work. So, I hope you will work with us. I appreciate it.

The CHAIRMAN. Senator Lincoln, and then Senator Kerry.

Senator LINCOLN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for hanging in there with us. We have just got lots of questions, and we hope we will be able to continue this dialogue even after today's hearing.

I represent a State that is tremendously dependent on services to rural areas. We have a disproportionate share of elderly that live in rural areas. They have many needs. They are, oftentimes, hard to serve. So, there are a lot of special needs in rural America.

I share the President's concern about the growing deficit, the historic deficit that we have in this country, and I want to work with him to do something about it. But I do have great concern that this budget reflects a disproportionate burden on rural areas and rural States.

The budget that the President submitted proposes to eliminate the Area Health Education Centers, or the AHEC program. These centers are academic/community partnerships that train health care providers in sites and programs that are really responsive to State and local needs.

There are six AHEC centers in Arkansas, and the program overall has greatly improved the State's health manpower distribution needs over the last 3 decades, including the placement of 503 family physicians in 68 of the State's 75 counties to date, and that is not an easy task; getting physicians into rural counties to serve is a phenomenal question for rural America. These centers have also trained hundreds of nurses, pharmacists, and allied health professionals who are now scattered across our State.

My question is, because of its success, why does the President's budget eliminate this highly effective program?

Secretary LEAVITT. Senator, I think that likely falls into the category of, if we had more money, that would be a good place to spend it.

Senator LINCOLN. So these people are not important?

Secretary LEAVITT. We actually have included about $25 million into the Medicaid bill. Judgments had to be made. Of course they are important. That is what Medicaid, for example, is all about, is serving. What we have been talking about today is ways to find a capacity to serve more people, not fewer.

Senator LINCOLN. But this is a program that does that. That is what is so interesting to me. I mean, this is a program that has been effective. It has done outreach in rural communities. It has brought in medical centers and others to bring physicians and other medical professionals into these more difficult to serve areas.

I guess I would just echo what Senator Kerry has said there, that in terms of this budget, it is really hard and it is misleading to think that we are going to do something about the debt from the budget here and the decisions that have been made, when you see a parallel effort to make permanent tax cuts to the ultra-wealthy, none of which live in these areas where these medical professionals serve, in most instances. So, I would just say, the answer that, if there were more money we would like to do it, to me, is of great concern.

Secretary LEAVITT. Senator, let me make clear what I am responding to. Do we desire to have more medical providers in rural America? The answer to that is yes. Did we believe that that particular program, on balance, was the best investment and way to get it there? No.

Senator LINCOLN. Then what do you propose to replace it with?

Secretary LEAVITT. The Medicaid bill, as I mentioned, has $25 million in it that we believe will go a long ways in replacing it.

Senator LINCOLN. With what? I mean, it is just $25 million. What are you going to do? These programs that exist now, are you going to fund them through that? Are you just going to leave these AHEC projects that we have invested the time and resources in? Are they going to be empty buildings?

Secretary LEAVITT. Decisions have to be made, and that is a decision that was made in this budget.

Senator LINCOLN. So you made the decision, but there is no policy decision or no ideas of what you are going to replace it with at this point, other than $25 million.

Secretary LEAVITT. If you are talking about the entire area of rural health, I have addressed that on a number of different occasions. But the Medicare bill has $25 billion in payments that will go to rural providers.

Senator LINCOLN. Medicaid or Medicare?

Secretary LEAVITT. Medicare. I may have said Medicaid before. I meant Medicare.

Senator LINCOLN. No, you said Medicare.

Well, getting to that, I guess, as we see the new estimates that the new Medicare drug benefit will cost, and looking at where we dealt with a lot of those issues and the costs, and many of our concerns, those of us that supported and worked on that bill, the concern that we were not doing as much, as Senator Wyden mentioned, to bring down those costs.

I agree with him, that cost containment and being able to make sure we have got a real handle on that is going to be very effective.

I guess my hope is that the administration will have more suggestions on how to control those escalating drug costs. Would you consider MEDPAC's findings that Medicare has overpaid managed care plans in Medicare and proposes cutting those overpayments? Do you agree with that?

Secretary LEAVITT. I do not know, Senator. I am not familiar with the precise comment that you are referring to. I know about MEDPAC, but I do not know about the specific finding that you are referencing and I cannot respond to that.

Senator LINCOLN. What they have most recently come out with, you are not familiar with that?

Secretary LEAVITT. I am not familiar with the specific suggestion.

Senator LINCOLN. The overpayment to managed care. We supplement managed care tremendously in the Medicare Reform Act that we did. It was a tremendous amount. I think it was $12 billion, or something like that, that we supplement managed care with. We knew then that we were overpaying them, and MEDPAC has confirmed that in their studies, that we are overpaying them.

Secretary LEAVITT. I will do my best to get a hold of that report. I have been here 21 days, Senator. I am doing my best to deal with the larger issues first and drill down.

The CHAIRMAN. You could answer that in writing, I believe. Would you be willing to do that?

Secretary LEAVITT. I would be happy to.

Senator LINCOLN. Thanks.

[The information appears in the appendix.]

The CHAIRMAN. Senator Kerry?

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

Mr. Secretary, I would like to pick up where we left off. I am not trying to suggest somehow that you did something wrong with respect to what happened in Utah. But I am trying to suggest that there is a reality to the choices, as you know better than anybody because you were a governor, that governors make. The past is prologue to the future. I mean, we have to look at the behavior and how States have implemented these programs through the years.

If 17 States only used 10 percent of the money previously—and you yourself made a different choice, and it is a rational choice.

You chose to cover people under the SCHIP money that we provided, so you were able to expand. The problem is, there are still 40,000 kids in Utah who do not have any coverage. Still, today, 40,000 children have no health insurance in Utah. Eleven million kids under 21 have no coverage in America.

The question I am asking is, and a lot of people are asking, is what you are offering really going to change this? Now, based on past experience, particularly when we are cutting $60 billion and the States are in the throes of trying to figure out how they are going to provide Medicaid services, what is the incentive to go out and enroll a whole bunch more people when they have not done it in the past and we are not getting rid of the enrollment barriers themselves? There is a term of art called churning. Are you familiar with it?

Secretary LEAVITT. I am.

Senator KERRY. So the churning that takes place is going to set us to whatever degree it is. We do not get ahead of the game here unless you change the enrollment barriers, unless people do not have to re-enroll every 3 months, in some States, unless they do not have to go to the office to do it, or so forth.

That is what I am trying to get at: how do we get rid of the barriers, boldly reach out, and insure all these kids? Now, you have got a program called "Cover the Kids" that is going to leave millions of kids out.

Here is the other problem, and I would like you to address it. I understand the President and the administration have a choice of tax credits as an approach. The problem is, you have $125 billion that is tax-credit-oriented out of the money you are talking about spending.

You have a refundable credit of $1,000 to low-income people. But $1,000 is not enough to be able to purchase health care, and particularly push towards the higher deductible plans, which is what you are doing.

So the notion that you are really covering people with that $75 billion is, in my judgment and in the judgment of many experts, a fiction, because they cannot afford the premiums. That is not enough money, and they are being pushed to high deductibles.

The other $51 billion goes to people who already are insured and it is an incentive to actually push them into the higher deductible plan, but it will not do anything to provide that broader coverage.

So let me ask you, how many children specifically are going to get coverage with your Cover the Kids plan?

Secretary LEAVITT. Let me begin, essentially, where you did. The assumption and the way you have portrayed it, is that States do not desire to see children covered. They do. When I became governor, and when I left being governor, we had cut that 40,000 basically in half by proactively going out and finding children and providing them with some means of being able to get health care.

Senator KERRY. Under the SCHIP coverage.

Secretary LEAVITT. Yes. And many other ways as well.

Senator KERRY. Right.

Secretary LEAVITT. It is something I take great pride in, the fact that when I became governor, 86 percent of the children had it; when I left, 94 percent had it. I take great satisfaction in that fact.

The President recognizes that not every State has done that well, and that despite their best efforts, they might not still have reached all of the children. For that reason, he has chosen to put $1 billion in the budget to help find them.

But not just for State governments to find them, to give some of that money to Indian tribes, to give it to community organizations, to give it to schools to find children who are currently not covered and then provide them in some way.

Senator KERRY. No. I understand that. I respect that. But the question is, given the past experience and the churning factor I just described, how many kids are actually going to get covered here?

Secretary LEAVITT. Let me go on and I will do my best to respond.

Senator KERRY. Fair enough. Fair enough.

Secretary LEAVITT. The second point I would make is, to presume that the only way in which a person can gain health insurance is through a government program is fundamentally wrong. To assume that only those who receive a health insurance policy are the ones who get health care is fundamentally wrong.

Currently, among that 35 to 45 million people that we know do not have health insurance today, 6.1 million of them, in some way, will have received health care at one of our community health centers. The Indian Health Service is another. We do not include those among the rolls of the insured.

The President has put forward a proposal, as you indicated, $125 billion over the next 10 years. Twelve to fourteen million people will have health insurance within their reach.

Now, how many of those specifically will be children, I do not know. But I believe we could provide you with that, and I would be happy to provide you with the best possible answer I have.

Senator KERRY. I appreciate it.

[The information appears in the appendix.]

Secretary LEAVITT. But the goal here is to provide coverage to more people.

Medicaid. We have had a great deal of discussion on Medicaid. The fundamental issue there is, how can we take the resources that we currently have and cover more people and keep people who currently have coverage from being dropped because of meaningless, rigid inflexibility?

Your State is a prime example. They have, through waivers, been able to find ways of being able to reach out to those who currently have not qualified. That is the commitment we are making: 12 to 14 million additional people over the next decade.

The CHAIRMAN. Senator Schumer. Oh. Senator Kerry, you looked at me. Senator Kerry?

Senator KERRY. Mr. Chairman, I would just like to ask, if you could, also submit how many low-income uninsured will get coverage under the refundable tax credit for high deductible insurance programs and, finally, how many people who are already insured that benefit from the $51 billion in tax credits to the higher income earners. If those questions could also be responded to.

Secretary LEAVITT. I will do my best to respond, Senator.

The CHAIRMAN. And also Senator Lincoln said she was going to submit some questions in writing.

Secretary LEAVITT. We will submit them in writing.

The CHAIRMAN. Thank you, Mr. Secretary.

[The information appears in the appendix.]

The CHAIRMAN. Senator Schumer?

Senator SCHUMER. Thank you, Mr. Chairman, and to you, Mr. Secretary. To the Chairman and the committee, I apologize. We had Alan Greenspan at the Banking Committee, so I am sorry I missed the beginning of your testimony.

I have three questions. The first is on the Medicare drug benefit cost estimates. We have heard a lot about these. There is a debate whether we are talking about an apples to apples comparison or an apples to oranges comparison. We have said that in an apples to apples comparison, the new estimate is pretty close to the old estimate, with a few expensive years added at the end.

But as I understand it, and I think Senator Baucus talked a little about this while I was not here, that the assumptions underlying the new estimate have changed substantially since the first estimate was completed, including very important assumptions about enrollment and employer participation in the program.

If that is true, then the similarity of the numbers may be more fishy than if the numbers were different. Can you explain? It is almost as if you wanted to have the same number and the assumptions worked their way back.

Can you explain the changes in the assumptions underlying these two estimates and the justification for those assumptions?

Secretary LEAVITT. That is a level of detail we will need to provide you in writing. I am not able to do it myself.

Senator SCHUMER. All right. I would ask unanimous consent that that be done.

[The information appears in the appendix.]

Senator SCHUMER. The next question leads to the Medicaid cuts, which most of my colleagues have talked about, and the cost shifting to the States. As a member of the NGA, you signed off on an NGA resolution opposing caps and cuts to Medicaid. We all know that.

But as part of that resolution, you stated explicitly that States believe that Medicaid is chronically underfunded because the Federal Government is shifting long-term care and other costs to governors and State taxpayers.

You are now proposing these rather severe cuts to the Medicaid program. How can you reconcile not addressing this cost shifting burden and actually making it worse? Because not only will these cuts directly affect the quality of services available to beneficiaries, but as a former governor, I am sure you know it is going to force States, once they shut down programs altogether, to raise property taxes. In my view—I do not know if it is yours—property tax is the most hated tax, more than a sales tax, more than an income tax.

In addition, it is going to put a greater strain on private coverage. That will cause premiums to go up, and it will severely threaten access to quality nursing home care for people of all income levels.

What is your response to this, particularly on the cost shifting? We all know, every time there is a cut here, it does not decrease the program or even make it more efficient, but it ends up ending up on the back of the local property taxpayer.

Secretary LEAVITT. Senator, the view that was expressed at that time is still my view. To the extent that we do not provide States with some means of being able to deal with the rapidly expanding population of elderly and disabled, we will rapidly approach a point when they will not be able to do so.

That is the reason that the President has proposed his New Freedom Initiative, as an example, giving States the capacity to expand home and community care as an alternative. It is an alternative that people want, that States desire, and that would be in the interest of Medicaid because it would allow us to cover more people with those dollars that are currently being invested.

Senator SCHUMER. Why would you not do it the other way, help the States ease into these things and then save the money, as opposed to making the cuts? Again, it is sort of, cart before the horse. You are making the cuts and you say, well, maybe some of these other things will happen.

My experience in my State, obviously a very big Medicaid State, is that that does not. Washington always says that, oh, it is not going to shift costs, it is going to just make things more efficient, and it ends up doing far more of the cost shifting than of the efficient sizing.

If you could come up with a better way, I would love it, and help the States move there. But I do not think you have here. I think the motivation here was a budget cut, not improving the efficiency of the program.

Secretary LEAVITT. Senator, we have three categories of reduction in this budget. The first, is a clear statement that we are overpaying for pharmaceuticals.

Senator SCHUMER. Hear, hear.

Secretary LEAVITT. All right. We are together on that one.

Senator SCHUMER. Yes. But I have a question on that, next.

Secretary LEAVITT. All right. The second, is that there are people in America who are giving their assets to their children to qualify for Medicaid.

Senator SCHUMER. Right.

Secretary LEAVITT. We find that troubling, and so do the States.

Senator SCHUMER. Yes.

Secretary LEAVITT. So we are together on that one. The third, we have a very straightforward, honest dispute with States about the way they are funding their share. We are being straight up about our disagreement with many of their practices, and are desirous to work through, one at a time, with them what we believe are unfair shifts that they are making.

Now, it would not be the first time that partners in a good and noble cause have disagreed with one another on who ought to pay for what. But we have a serious disagreement.

Senator SCHUMER. Understood. Let me ask you this. If you really have the interests of the States at heart, would you not tell them, and it would be in their incentive as well, that the savings made would go back into the Medicaid program?

We know, there is an exploding cost of medical care for everyone, Medicaid, Medicare and private. Would that not be a much better incentive to the States, and would the administration consider that?

Secretary LEAVITT. Senator, over the next 10 years, between the States, our partners, and the Federal Government, we will spend $5 trillion. It will be among the fastest-growing categories on this budget now and in the next 10 years. We know that. The changes that we are making will reflect a difference between 7.6 percent growth and 7.4, and we are trying to balance it.

Senator SCHUMER. I am just saying, would you not have greater cooperation and incentive from the States if you shared some of the cost savings and let them put it back in the program?

Secretary LEAVITT. Senator, we are looking for ways to work with the States in every category. I am meeting with governors. I have told them I will be at the table as long as it is necessary to produce a proposal that is bipartisan that we can bring to this committee.

Senator, I hope very much, if we are able to produce that, that we could come to the Finance Committee and say, here is a proposal; work with us so we can keep from having to drop these optional populations. That is what the governors are telling me, and I suspect they are telling you the same thing.

Senator SCHUMER. You bet. At least one of them is.

One final question. I appreciate the Chair. This might help you save some money, and I am a little befuddled by the policy. It is on an issue that I have been very involved with, the generic drug situation. These are about the authorized generics.

On the heels of the reports about the cost of the Medicare drug benefit, taxpayer-supported drug purchases are getting greater scrutiny, as they should. The last time you were here, I asked you a question in writing about authorized generics, which are generic versions of drugs that are produced by a brand manufacturer on the same lines as the brand-label drug. In your response you stated, "CMS treats authorized generics the same as the brand drug."

That is what your answer to me said. However, I now understand that this policy only applies when CMS is deciding which rebate should be paid on the authorized generic version of the drug. It does not apply when CMS decides what rebate should be paid on the brand drug.

Instead, CMS sort of conveniently treats an authorized generic as different from the brand drug in this instance, which allows the brand company to escape reporting the price of the authorized generic when it reports its best price to the Medicaid program. That is costing a lot of money. It is helping the pharmaceutical industry, but it is costing a lot of money.

In effect, this policy prevents Medicaid, the program we are talking about, from getting the highest rebates on brand drugs allowed under the law. That is the justification for CMS's inconsistency here?

Secretary LEAVITT. Senator, the FDA does not have authority to prohibit the marketing of authorized generic manufactured drugs, pursuant to the——

Senator SCHUMER. I know. I know what the FDA can do. I am asking about CMS's bifurcated policy here, which only seems to

benefit the drug companies and costs the Federal taxpayer more money. If we want to save money on drugs, this is a good way to do it. Why are you not?

Secretary LEAVITT. CMS treats authorized generics as innovative drugs and they are subject to a higher rebate that is required by law. I do not see an inconsistency, but I would be glad to respond to you further in writing.

But while I am on the subject of prescription drugs, may I say——

Senator SCHUMER. Why is there not an inconsistency? Just explain that to me. You want to save money on the one. Why not save money on the other, get the best price? It is like a loophole. It seems to me, it is sort of a nice little deal between the drug companies and someone quietly at CMS.

As I understand it, you could do just what I asked with a flick of your pen. That does not require any legal change. Right. My staff says that is correct, so it must be.

Secretary LEAVITT. My staff says it is not, so it must not be. [Laughter.]

Senator SCHUMER. Oh. Well, if it were, if we could get some understanding by your legal counsel that it was allowed by law, would you do it?

Secretary LEAVITT. Why do we not conduct this conversation in a way that will allow us to find out, (A) what the truth is, and (B) we will be happy to be responsive.

Senator SCHUMER. Right. I am just trying to save you a little money here.

Secretary LEAVITT. Thank you. I am up for that.

Senator SCHUMER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Schumer.

Now, Senator Baucus. Senator Baucus has one question and then I think we will be able to adjourn.

Senator BAUCUS. Actually, two.

The CHAIRMAN. Two questions. You can have three or four, if you want.

Senator BAUCUS. I appreciate that. Thank you.

The first has to do with, as I understand it, CMS phasing out risk adjustment as it applies to health plans. As you well know, CMS has announced its intent to continue to increase payments to the plans to cover the savings they achieved by attracting healthier patients. That is in 2006. Also, CMS wants to phase out these overpayments beginning in 2007.

As you well know, back in 1997, Congress required CMS to account for risk adjustment. In legislation, we asked CMS, over a period of time, 10 percent the first year and then back to a full 100 percent by 2006 and thereafter. Why are you phasing out, why paying back? Why phased-out risk adjustment?

If the plans are getting overpaid, and Congress made that determination for having a higher percentage of healthier patients, why should there not be risk adjustments in payments to the health plans as there is in the private sector generally? What is the rationale here, and what is the schedule?

Secretary LEAVITT. Given enactment of the Medicare Modernization Act and the creation of the Medicare Advantage program, CMS

strongly recommended, as you have indicated, that the risk adjustment, or the adjuster, not be phased in the same year as the program begins.

Medicare Advantage plans are expected to offer seniors richer benefit packages with significantly lower out-of-pocket costs, and they were focused on being able to make certain that there were programs with low out-of-pocket costs for that target group.

It is my sense that trying to implement a new payment policy that would be based on the program's population of enrollees in the first year of the program does not make sense and would not allow us to maximize the number of people who will participate in the program. As has been mentioned, our objective is to provide a plan that will provide millions of Americans access.

Senator BAUCUS. But that is not the issue. The issue is not whether to provide benefits. The issue is, should there be an adjustment in the payment to plans that attract healthier clientele versus less healthy?

Of course, it is in that plan's best interests to get the healthiest possible, because then the payments are lower and the cost to the plan, therefore, is less. I just do not understand why we do not have honest accounting here, honest risk adjustment. I understand the point about phasing in and so forth, and a little bit of timing. But I do not understand the policy of phasing out risk adjustment.

Secretary LEAVITT. When you are dealing with risk adjustment, you are dealing with what is someone's opinion of what might happen. We do not know with certainty.

Senator BAUCUS. You have actuaries and you have data. I am not saying this is a perfect science.

Secretary LEAVITT. But we do not know with certainty when it will, or who will.

Senator BAUCUS. Right.

Secretary LEAVITT. But we have made an assumption. What you are questioning is, why did we make an assumption one way and why did we make it the other way? The answer is very clear.

Senator BAUCUS. I am asking, why make the same payments, irrespective of the risk that the plans have with their patients?

Secretary LEAVITT. Because we wanted to create a low-cost alternative for those beneficiaries to assure that they were able to sign up for the plan.

Senator BAUCUS. All right. I would just ask you to take a good, hard look at that. I wonder if plans are being overpaid as a consequence of CMS policy. That is my point. I know you do not want to over-pay, and I urge you to look back to make sure that you are not.

Secretary LEAVITT. I accept your point. Thank you.

Senator BAUCUS. A couple of questions about health care tax credits. Working on the drug bill, I pushed hard for trade adjustment assistance for people who were thrown out of work. We worked hard on that and we pushed very hard to get a government payment of 65 percent. That is, the person that is out of work and applies, and in the private market it would have to be at 35 percent.

The GAO just recently conducted a report. The long and the short of it is, it concluded that only 6 percent of those eligible have

enrolled. Only 6 percent. In some States, it is just amazing, that is, what insurance companies are charging. Therefore, the 35 percent is just prohibitive. They just cannot sign up. It seems as if a 65-percent credit is just odd enough to purchase a credible, affordable package.

In addition to that, the cost of administering the program is about 35 percent of total spending. Thirty-five percent. There are a lot of payments going to contractors here.

In light of all that, I wondered what lessons we have learned from that as the administration proposes expanding health care tax credits. If you look at the history of TAA, it is not good, which is disappointing to me. I had hoped it would amount to something, but it is not near what we had hoped it would be.

I would like for you to comment on that if you could, please.

Secretary LEAVITT. It seems like a very legitimate question. It is not one that I am capable of being able to answer today. Would you be willing to allow me to respond in writing?

Senator BAUCUS. I thought you had all the answers.

Secretary LEAVITT. All but that one.

Senator BAUCUS. All right. Yes, if you could. This is fairly important. I have forgotten the exact number, but it is, like, $65 billion worth in the President's budget, in the President's health care plans. I think it is that high. It is a very high number.

Secretary LEAVITT. As you are aware, those are all administered by the Secretary of Treasury, not the Secretary of HHS. But it is something I would like to know about, and we will do our best to consult with them and respond.

Senator BAUCUS. Since it is part of the President's health plan——

Secretary LEAVITT. That is something I want to know about.

Senator BAUCUS [continuing]. I think you probably will know about it.

Finally, I would like to have the State-by-State breakdown of the Medicaid costs by the end of the month, please.

Secretary LEAVITT. Senator, we will do all we can. We will give you everything we have by that time.

Senator BAUCUS. And I know you can get it all for us by then, because you have got a lot of bright people down there. You have demonstrated today just how earnest you are in doing the right thing.

Secretary LEAVITT. Well, Senator, I am both earnest, and I do want to do the right thing.

Senator BAUCUS. Thank you.

Secretary LEAVITT. I will tell you that these payment issues are complex. It essentially requires auditing the various plans. We can come up with estimates, but they will be disputed by the States.

Senator BAUCUS. I understand. All I am asking is, we do the best we can.

Secretary LEAVITT. We will do the best we can.

Senator BAUCUS. Because I think it is good public policy for us to have as much information as we can have as we get into the budget process here.

Secretary LEAVITT. We will give you everything we have that is credible.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you for coming, Secretary Leavitt. I assume we just got a lesson that we should have waited another month to have you, and then you would have answers to all of those questions.

Secretary LEAVITT. That is right. Missed by one.

The CHAIRMAN. I can understand being on the job only 12 days. We appreciate your cooperation, because it has really expedited the very heavy workload of this committee. Thank you.

[Whereupon, at 12:19 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MICHAEL O. LEAVITT

Good morning, Mr. Chairman, Senator Baucus, and members of the committee. I am honored to be here today to present to you the President's fiscal year 2006 budget for the Department of Health and Human Services (HHS). The President and I share an aggressive agenda for the upcoming fiscal year, in which HHS advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the people's money.

In his February 2nd State of the Union address, the President underscored the need to restrain spending in order to sustain our economic prosperity. As part of this restraint, it is important that total discretionary and non-security spending be held to levels proposed in the fiscal year 2006 budget. The budget savings and reforms in the budget are important components of achieving the President's goal of cutting the budget deficit in half by 2009, and I urge the Congress to support these reforms. The fiscal year 2006 budget includes more than 150 reductions, reforms, and terminations in non-defense discretionary programs, of which 19 affect HHS programs. The Department wants to work with the Congress to achieve these savings.

The President's health agenda leads us towards a Nation of healthier Americans, where health insurance is within the reach of every American, where American workers have a comparative advantage in the global economy because they are healthy and productive, and where health technology allows for a better health care system that produces fewer mistakes and better outcomes at lower costs. The fiscal year 2006 HHS budget advances this agenda.

The fiscal year 2006 HHS budget funds the transition towards a health care system where informed consumers will own their personal health records, their health savings accounts, and their health insurance. It enables seniors and people with disabilities to choose where they receive long-term care and from whom they receive it. Equally important, it builds on the Department's Strategic Plan and enables HHS to foster strong, sustained advances in the sciences underlying medicine, in public health, and in social services.

To support our goals, President Bush proposes outlays of $642 billion for HHS, a 10-percent increase over fiscal year 2005 spending, and more than a 50-percent increase over fiscal year 2001 spending. The discretionary portion of the President's HHS budget totals $67 billion in budget authority and $71 billion in program level funding. In total, the HHS budget accounts for almost two-thirds of the proposed Federal budget increase in fiscal year 2006.

The Department will direct its resources and efforts in fiscal year 2006 towards:

- Providing access to quality health care, including continued implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;
- Enhancing public health and protecting America;
- Supporting a compassionate society; and
- Improving HHS management, including continuing to implement the President's Management Agenda.

Americans enjoy the finest health care in the world. This year's budget provides opportunities to make quality health care more affordable and accessible to millions more Americans.

MEDICARE

HHS will be working in fiscal year 2006 to successfully implement the Medicare Modernization Act (MMA), including the Medicare Prescription Drug Benefit and

the new Medicare Advantage regional health plans. I know there has been a lot of discussion over the past week about the cost of the new Medicare proposal, and I want to address that issue today. Recent press reports have inaccurately claimed that our cost estimates have dramatically increased. This is simply untrue.

The passage of time is the main reason that the fiscal year 2006 budget shows a higher net Federal cost ($723.8 billion) for 2006–2015 than the cost estimate for 2004–2013. In the original cost estimates, the first 2 years in the 10-year budget window were for years before the new drug benefit was implemented (2004 and 2005). The 10-year budget window reflected in the 2006 budget includes 10 full years of actual drug benefit spending. In effect, the passage of time has dropped 2 low-cost dollar year estimates (only transitional assistance spending) from the budget window and added 2 high-cost years, due to anticipated increases in average drug spending and the growth of the Medicare population. People should not be surprised that the numbers look different as a result of the advance of time.

Some individuals have asserted that the estimate for MMA implementation is now over a trillion dollars. This assertion is completely unsupported by facts. The trillion-dollar figure is a gross estimate that neglects to subtract out hundreds of billions of dollars of Federal revenue, including beneficiary premiums, State payments, and other offsetting Federal savings. Focusing exclusively on gross spending levels without considering the offsetting savings creates false impressions and does a disservice to the budget process and to Medicare beneficiaries.

Moving beyond the subject of funding, I hope we can all begin to focus on the task at hand: ensuring successful implementation of a strengthened and improved Medicare program with the new prescription drug benefit. Between now and January 1, 2006, we have a lot of work to do, and I give you my commitment that we will not fail. I know not everyone in this committee supported the passage of the Medicare bill, but it is now law, and in 10½ months, almost 43 million Americans will be eligible to receive much-needed assistance with the high cost of prescription drugs. Let us put aside our differences and work together towards the goal of ensuring that seniors and people with disabilities are successfully signed up for their new benefits. We all owe that to them.

UNINSURED

In fiscal year 2006, the President also proposes steps to promote affordable health care for the approximately 45 million Americans who are currently uninsured. The President proposes to spend more than $125.7 billion over 10 years to expand insurance coverage to millions of Americans through tax credits, purchasing pools, and Health Savings Accounts. To improve access to care for many uninsured Americans, the President's budget requests $2 billion, a $304 million increase from fiscal year 2005, to fund community health centers. This request does two things. It completes the President's commitment to create 1,200 new or expanded sites to serve an additional 6.1 million people by 2006. By the end of fiscal year 2006, the Health Centers program will deliver high quality, affordable health care to over 16 million patients at more than 4,000 sites across the country. In 2006, health centers will serve an estimated 16 percent of the Nation's population who are at or below 200 percent of the Federal poverty level. Forty percent of health center patients have no health insurance, and 64 percent are racial or ethnic minorities. In addition, the President has established a new goal of helping every poor county in America that lacks a community health center and can support one. The budget begins that effort by supporting 40 new health centers in high-poverty counties.

Moreover, the President proposes a budget that would expand access to American Indian and Alaska Native health care facilities, staff six newly built facilities to serve the growing eligible population of federally recognized members of Native American tribes, and address the rising costs of delivering care. In fiscal year 2006, the Indian Health Service will provide quality health care through 49 hospitals, more than 240 outpatient centers, and more than 300 health stations and Alaska village clinics. In total, the President proposes increasing health support of federally recognized tribes by $72 million in fiscal year 2006, for a total of $3.8 billion.

The President and the Department are also committed to resolving the growing challenges facing Medicaid. Medicaid provides health insurance for more than 46 million Americans, but, as you are all aware, States still complain about overly burdensome rules and regulations, and the State-Federal financing system remains prone to abuse.

This past year, for the first time ever, States spent more on Medicaid than they spent on education. Over the next 10 years, American taxpayers will spend nearly $5 trillion dollars on Medicaid in combined State and Federal spending. The Department proposes to make sure tax dollars are used more efficiently by building on the

success of the State Children's Health Insurance Program (SCHIP) and waiver programs that allow States the flexibility to construct targeted benefit packages, coordinate with private insurance, and extend coverage to uninsured individuals and families not typically covered by Medicaid.

The President proposes to give States more flexibility in the Medicaid program in order to enable States to increase coverage using the same Federal dollars. The tools we have at our disposal today were not available when Medicaid was created. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. Over the past 10 years, Medicaid spending doubled. At its current rate of growth (7.4 percent), the Federal share of Medicaid spending would double again in another 10 years.

The growth in Medicaid spending is unsustainable. I intend to enter into a serious discussion with governors and Congress to decide the best way to provide States the flexibility they need to better meet the health care needs of their citizens.

The President plans to expand coverage for the key populations served in Medicaid and SCHIP by spending $15.5 billion on targeted activities over 10 years. The budget includes several proposals to provide coverage, including the "Cover the Kids" campaign to enroll more eligible uninsured children in Medicaid and SCHIP. In addition, the extension of the Qualified Individual (QI) and transitional medical assistance programs will ensure coverage is available to continue full payment (subject to a spending limit) of Medicare Part B premiums for qualified individuals, and provide coverage for families that lose eligibility for Medicaid due to earnings from employment. Also, community-based care options for people with disabilities will be expanded through the President's New Freedom Initiative, including authorizing $1.75 billion over 5 years for the Money Follows the Person Rebalancing demonstration.

Overall, these efforts to expand health insurance coverage, as well as those in other Departments, work together to extend health care coverage and health care services to millions of people. Thanks to the comprehensive nature of this agenda, workers are already investing money tax-free for medical expenses through Health Savings Accounts, Americans have increasing flexibility to accumulate savings and to change jobs when they wish, and more Americans are accessing high-quality health care. We estimate that 8 to 10 million additional people will gain health insurance over the next 10 years. Together, these efforts to expand insurance coverage and improve the Medicaid and SCHIP programs will cost approximately $140 billion over the same period.

At the same time, we are taking steps to ensure States can use their Medicaid funds to the fullest potential to reach more individuals in need of health care. The budget includes proposals that will assure an appropriate partnership between the Federal and State governments. We would like to work cooperatively with the States to respond to the challenges in Medicaid. We must eliminate the vulnerabilities that threaten Medicaid's viability. In our budget, we have proposed a series of legislative changes that will ensure Medicaid dollars are used appropriately to fulfill the program's purpose to provide health care coverage for low income families and elderly and disabled individuals with low incomes. Under this proposal, inappropriate Federal spending on Medicaid intergovernmental transfers and spending resulting from other current loopholes in Medicaid law will decrease by $60 billion over 10 years.

As a former governor, I understand the pressure on States in developing their budgets, particularly given the lack of flexibility in the current Medicaid law. However, some State officials have resorted to a variety of inappropriate loopholes and accounting gimmicks that shift their Medicaid costs to the taxpayers of other States. Obviously, States that are not engaging in these activities will not be affected by the proposals in the same manner as States that are. Collectively, the overall impact of the $60 billion 10-year decrease in Federal Medicaid spending on States will in reality be about $40 billion, because by changing the calculation of prescription drug payments to be based on the average sales price and by tightening asset transfer rules, approximately $20 billion in State spending will be saved. And it should be noted that two-thirds of the savings will occur beyond the initial 5-year budget window.

PREPAREDNESS

The HHS fiscal year 2006 budget will also build on the Department's achievements in strengthening our ability to detect, respond to, treat, and prevent potential disease outbreaks due to bioterrorist acts. It will enable the National Institutes of Health (NIH) to increase research efforts in developing bioterrorism countermeasures and to fund biomedical research at current levels, it will allow the Centers

for Disease Control and Prevention (CDC) to expand the Strategic National Stockpile, and it will support the Food and Drug Administration's efforts to defend the Nation's food supply. This proposal requests $4.2 billion to continue this work, an increase of almost 1500 percent over 2001. This request raises to $19 billion the cumulative amount invested since September 11, 2001 on public health preparedness, and that investment is showing tangible results.

Let me mention just a few of the highlights and also note that HHS works in close cooperation with DHS on many of these activities, including the medical surge initiative and food node threats and vulnerability assessments:

- HHS has a responsibility to lead public health and medical services during major disasters and emergencies. To support this, we are requesting $70 million for the Federal Mass Casualty Initiative to improve our medical surge capacity. We are also investing $1.3 billion to support work at CDC and the Health Resources and Services Administration (HRSA) to improve State and local public health and hospital preparedness.
- In the event of a major health emergency, one posed by either nature or through the intentional use of a weapon of mass destruction, the Strategic National Stockpile would provide Americans with almost immediate access to an adequate supply of needed medicines. In order to ensure the effectiveness of the Stockpile, we're requesting $600 million to buy additional medicines, replace old ones, provide specialized storage, and get any needed medicines and supplies to any location in the United States within 12 hours. $50 million of this will go to procure portable mass casualty treatment units.
- We're requesting $1.9 billion for the Food and Drug Administration (FDA)—an increase of $81 million over 2005. $30 million of this request would be directed to improving the agency's national network of food contamination analysis laboratories and to supporting vital research on technologies that could prevent threats to our food supply. HHS also proposes to dedicate $6.5 million more than in fiscal year 2005 to evaluating and communicating drug safety risks to the public and applying scientific expertise to explore the risks of medical products already on the market.

We now have a heightened awareness that the Nation's critical food safety infrastructure must be better protected. FDA quickly learned that pursuing more field exams, alone, is not the most effective strategy for providing this protection. The new Prior Notice requirement on the shipment of foods allows FDA to conduct intensive security reviews on products that pose the greatest potential bioterrorism risk to consumers in the United States. We intend to complement these inspection efforts with further improvements to the national network of food contamination analysis laboratories, and to provide support for vital research on technologies that could prevent threats to the food supply. Investments like these will allow FDA to work smarter in the future.

The Food and Drug Administration is an integral component in our efforts to promote and protect the health of the United States public. Its mission is broad, and the agency's decisions affect virtually every American on a daily basis. In addition to food defense, the proposed $81 million increase will be focused on achieving specific improvements in drug safety and medical devices.

The budget includes a total of $747 million for human drugs and biologics, an increase of $26 million. With these funds, we propose to strengthen FDA's Office of Drug Safety with an increase of $6.5 million, for a total of $33 million. This increase will better equip the Office to carry out Center-wide responsibilities for drug safety analysis and decision-making. Critical staff expertise will be augmented in such areas as risk management, communication and epidemiology. Increased access to a wide range of clinical, pharmacy and administrative databases to monitor adverse drug events will be obtained. Also, external experts will also be used to a greater degree to evaluate safety issues.

Medical device products regulated by FDA must be safe and effective. The budget requests $289 million, an increase of $12 million, to improve timely performance in the review of applications, as well as, maintaining consistent high standards of safety and quality. Additional funds will also be directed towards medical device post-market safety activities.

VACCINES

The fiscal year 2006 budget also includes targeted efforts to ensure a stable supply of annual influenza vaccine, to develop the surge capacity that would be needed in a pandemic, to improve the response to emerging infectious diseases before they reach the United States, and to improve low-income children's access to routine immunizations.

HHS plans to invest $439 million in targeted influenza activities in fiscal year 2006, in addition to insurance reimbursement payments through Medicare. The budget includes a 2-part $70 million approach to ensure industry manufactures an adequate supply of annual influenza vaccine. The Vaccines for Children (VFC) program will again set aside $40 million in new resources to ensure an adequate supply of finished pediatric influenza vaccine. The discretionary Section 317 program will use $30 million to get manufacturers to make additional bulk monovalent vaccine that can be turned into finished vaccine if other producers experience problems, or unusually high demand is anticipated.

To improve low-income children's access to routine immunizations, the budget includes legislative proposals in VFC that I believe should be strongly supported by the members of this committee. This legislation would enable any child who is currently entitled to receive VFC vaccines to receive them at State and local public health clinics. There are hundreds of thousands of children who are entitled to VFC vaccines, but can receive them only at HRSA-funded health centers and other Federally Qualified Health Centers. When these children go to a State or local public health clinic, they are unable to receive vaccines through the VFC program. This legislation will expand access to routine immunizations by eliminating this barrier to coverage and will help States meet the rising costs of new and better vaccines. As modern technology and research have generated new and better vaccines, that cost has risen dramatically. For example, when the pneumococcal conjugate vaccine became available, it increased the cost of vaccines to fully immunize a child by about 80 percent. FDA has recently approved a new meningococcal vaccine that will further raise the cost to fully immunize a child—making this legislation even more important.

To improve our Nation's long-term preparedness, NIH will invest approximately $119 million in influenza-related research—nearly 6 times the fiscal year 2001 level. The budget also increases the Department's investment to develop the year-round domestic surge vaccine production capacity that would be needed in a pandemic, including new cell culture vaccine manufacturing processes, to $120 million. These research and advanced development efforts will be complemented by expanding CDC's Global Disease Detection initiatives from $22 million to $34 million to improve our ability to prevent and control outbreaks before they reach the U.S.

OTHER BUDGET INITIATIVES

The toll of drug abuse on the individual, family, and community is both significant and cumulative. Abuse may lead to lost productivity and educational opportunity, lost lives, and to costly social and public health problems. HHS will assist States in fiscal year 2006 through the Access to Recovery program to expand access to clinical treatment and recovery support services, and to allow individuals to exercise choice among qualified community provider organizations, including those that are faith-based. This program recognizes that there are many pathways of recovery from addiction. Fourteen States and one tribal organization were awarded Access to Recovery funding in fiscal year 2004, the first year of funding for the initiative. This budget increases support for the Access to Recovery initiative by 50 percent, for a total of $150 million.

Expanding abstinence education programs is also part of a comprehensive and continuing effort of the administration, because they help adolescents avoid behaviors that could jeopardize their futures. Last year, HHS integrated abstinence education activities with the youth development efforts at the Administration for Children and Families (ACF), by transferring the Community-Based Abstinence Education program and the Abstinence Education Grants to States to ACF. The fiscal year 2006 budget expands activities to educate adolescents and parents about the health risks associated with early sexual activity and provide them with the tools needed to help adolescents make healthy choices. The programs focus on educating adolescents ages 12 through 18, to create a positive environment within communities to support adolescents' decisions to postpone sexual activity. A total of $206 million, an increase of $39 million, is requested for these activities.

Our request also includes approximately $18 billion for domestic AIDS research, care, prevention and treatment. We are committed to the reauthorization of the Ryan White CARE Act treatment programs and request a total of $2.1 billion for these activities, including $798 million for lifesaving medications through the AIDS Drug Assistance Program.

Finally, we constructed the fiscal year 2006 budget with the knowledge that health information technology will improve the practice of medicine. For example, the rapid implementation of secure and interoperable electronic health records will significantly improve the safety, quality, and cost-effectiveness of health care. To im-

plement this vision, we are requesting an investment of $125 million. $75 million will go to the Office of the National Coordinator for Health Information Technology, to provide strategic direction for development of a national interoperable health care system. $50 million will go to the Agency for Health Care Research and Quality to accelerate the development, adoption, and diffusion of interoperable information technology in a range of health care settings.

PROGRAM PERFORMANCE

The President and the Department considered a number of factors in constructing the fiscal year 2006 budget, including the need for spending discipline and program effectiveness to help cut the deficit in half over 4 years. Specifically, the budget decreases funding for lower-priority programs and 1-time projects, consolidates or eliminates programs with duplicative missions, reduces administrative costs, and makes government more efficient. For example, the budget requests no funding for a number of smaller, duplicative community services programs and the Community Services Block Grant, which was unable to demonstrate results in Program Assessment Rating Tool evaluation. The administration proposes to focus economic and community development activities through a more targeted and unified program to be administered by the Department of Commerce. It is due to this focused effort to direct resources to programs that produce results that I am certain our targeted increases in spending will enable the Department to continue to provide for the health, safety, and well-being of our People.

Over the past 4 years, this Department has worked to make America and the world healthier. I am proud to build on the HHS record of achievements. For the upcoming fiscal year, the President and I share an aggressive agenda for HHS that advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the people's money. I look forward to working with Congress as we move forward in this direction. I am happy to answer any questions you may have.

Questions for Secretary Leavitt
Senate Finance Committee Budget Hearing
February 16, 2005

The Honorable Charles Grassley
Chairman, Senate Finance Committee

Question 1:
As you are already aware, the Medicare Modernization Act avoided scheduled cuts to physicians in 2004 and 2005. However, CMS actuaries' project payment updates of negative 5 percent annually from 2006 to 2012. This is obviously a concern to members of Congress, seeing that it is unsustainable for physicians to receive continuous payment reductions for 7 to 8 consecutive years. It is vitally important that beneficiary access to physician services is not compromised.

The President's budget had a slight increase from 2005 to 2006 of $249 million – granted this amount is not sufficient to cover the mounting cost of eliminating the negative updates. What is the Administration's thinking on addressing the impending negative updates?

Answer:
We are fully cognizant of the potential implications of seven years of negative physician updates. However, Medicare needs to move away from a system that pays simply for more services, regardless of their quality or impact on patient health, and consequently contributes to reductions in the physician update under the current payment formulas, to a system that instead encourages and rewards efficiency and high quality care for the Medicare program and its beneficiaries. As it stands, the physician payment system does not always recognize clinically appropriate care.

In addition to providing adequate payments, Medicare's payment system for physicians should encourage and support them to provide quality care and prevent avoidable health care costs. After all, physicians are in the best position to know what can work best to improve their practices, and physician expertise coupled with their strong professional commitment to quality means that any solution to the problems of health care quality and affordability must involve physician leadership.

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 developing reporting and payment systems that enable us to support and reward quality.

Question 2:
It is also important to note that the President's budget included an estimated baseline in which physician spending decreased annually from 2006 through 2010. Do the annual decreases in the physician baseline reflect the negative updates that physicians are expected to receive in 2006 and beyond?

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 the reductions payment rates under the statutory formula. It should be noted that the projected reduction in physician spending for physicians' services over the next few years is much less than the reduction in payment rates for physicians' services.

Question 3:
Last year, for the first time in the history of Medicare, Congress created a link between quality services to Medicare beneficiaries and payment for those services. For 2005 through 2007, hospitals reporting specific measures of quality care are receiving a full update for inflation, or the full hospital market basket increase, while hospital that don't report this information are receiving an update of market basket minus 0.4 percent. This policy is providing an incentive for hospitals to make quality of care information available to patients and health professionals.

We are pleased that the overwhelming majority of hospitals choose to submit quality data and thus are receiving the full update for 2005.

The President's budget indicates that HHS will make more of an effort in 2006 to link Medicare payment to provider performance. What options are under consideration by HHS?

Answer:
As you know, quality of care for people with Medicare is a priority for this Administration and the President's FY 2006 budget continues to reflect this commitment. As you mentioned above, the President's budget indicates a desire to work with the Congress to build upon the notion of linking Medicare payment to provider submission of quality data, as was included in the Medicare Modernization Act (MMA), to examine ways to "pay for performance" across the Medicare program.

The Administration is continuing to work with stakeholders to develop quality measures in a number of different health care settings, including the hospital, skilled nursing facility, home health, end stage renal disease facility, and physician office settings. Further, we are examining a variety of payment approaches, testing these various models through demonstration projects we have initiated ourselves as well as those mandated by statute.

As part of this effort, the Centers for Medicare & Medicaid Services (CMS) has been active in promoting "pay for performance," with several activities underway or in development that use financial incentives for quality improvement, including the Premier Hospital Quality Incentive demonstration, the Physician Group Practice Management demonstration, the Medicare Care Management Performance demonstration, and the Medicare Health Care Quality demonstration.

Premier Hospital Quality Incentive Demonstration
In July 2003, CMS launched the first Medicare demonstration project that uses financial incentives to encourage hospitals to provide high quality inpatient care. The Premier Hospital Quality Incentive

demonstration rewards hospitals with higher Medicare payments when they deliver the best quality care. It involves a CMS partnership with Premier Inc., a nationwide organization of not-for-profit hospitals. The demonstration tracks hospital performance on a set of 34 widely-accepted measures of processes and outcomes of care for five common clinical conditions. The 17 measures included in Medicare's national hospital quality reporting program are a subset of these measures.

Through this demonstration, CMS aims to see a significant improvement in the quality of inpatient care by awarding bonus payments to hospitals for high quality in several clinical areas, and by reporting extensive quality data on the CMS web site. Early results indicate that the quality of care has improved significantly in hospitals participating in this groundbreaking Medicare pay-for-performance demonstration project

Physician Group Practice Demonstration
Ten large (200+ physicians) group practices across the country will be participating in this demonstration, which is the first pay-for-performance initiative for physicians under the Medicare program. This demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Mandated by Section 412 of the Benefits Improvement and Protection Act of 2000, the PGP demonstration seeks to: (1) encourage coordination of Part A and Part B services, (2) promote efficiency through investment in administrative structure and process, and (3) reward physicians for improving health outcomes.

During the three-year project, CMS will reward physician groups that improve patient outcomes by coordinating care for chronically ill and high cost beneficiaries in an efficient manner.
The demonstration seeks to align incentives for physician groups to manage the overall care of their patients, especially beneficiaries with chronic illness who account for a significant proportion of Medicare expenditures. Because they will share in any financial savings that result from improving the quality of care, the groups will have incentives to use electronic records and other care management strategies that, based on clinical evidence and patient data, improve patient outcomes and lower total medical costs.

The demonstration enables CMS the ability to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

Medicare Care Management Performance Demonstration
Authorized by section 649 of the MMA and modeled on the "Bridges to Excellence" program, this is a 3-year pay-for-performance demonstration focused on small and medium-sized physician practices in four states: Arkansas, California, Massachusetts, and Utah, with the support of the Quality Improvement Organizations in those states.

The demonstration is designed to promote the adoption and use of health information technology to improve the quality of patient care and reduce avoidable hospitalizations for chronically ill Medicare beneficiaries. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive bonus payments for managing the care of eligible Medicare beneficiaries.

Medicare Health Care Quality Demonstration
Section 646 of the MMA mandates a 5-year demonstration under which projects may be approved that examine health delivery factors that encourage delivery of improved quality in patient care, including:

(1) incentives to improve health care safety, quality, and efficiency; (2) use of best practice guidelines; (3) examination of variations in utilization and outcomes measurement and research; (4) shared decision making between providers and patients; and (5) culturally and ethnically sensitive health care delivery.

The demonstration will be designed to identify, develop, test, and disseminate major and multi-faceted improvements to the entire health care system. Physician groups, integrated delivery systems, and regional health care consortia are eligible to apply for the demonstration.
Projects may involve the use of alternative payment systems for items and services provided to beneficiaries, and they may involve modifications to the traditional Medicare benefit package.

The demonstration will identify best practices in terms of system designs that encourage greater quality, efficiency and effectiveness, and focus on ways to make payment more consist with these practices. CMS is finalizing the demonstration design and has released a Request for Information (RFI) for the application solicitation.

Question 4:
In January, MedPAC recommended that Congress also establish a quality incentive payment policy for physicians and home health care. What progress are you making in this area?

Answer:
As you know, quality of care for people with Medicare is a priority for this Administration and the President's FY 2006 budget continues to reflect this commitment. The Administration is continuing to work with stakeholders to develop quality measures in a number of different health care settings, including the physician office and home health settings. Further, we are examining a variety of payment approaches, testing these various models through demonstration projects we have initiated ourselves as well as those mandated by statute.

Physicians
The Ambulatory care Quality Alliance (AQA), a private-public organization representing clinicians, consumers, purchasers, health plans, and others, recently selected a "starter set" of 26 clinical performance measures for the ambulatory care setting. The mission of the AQA is "to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring, reporting and improving performance at the physician level." A secondary aim of the AQA is to promote uniformity in order to provide consumers and purchasers with consistent information and to reduce the burden on providers.

The starter set of ambulatory measures represents an initial set of measures that physicians may use to collect data and report their performance. It is intended to provide clinicians, consumers, and purchasers with a set of quality indicators that may be utilized for quality improvement, public reporting, and pay for performance programs. The starter set includes (1) prevention measures for cancer screening and vaccinations; (2) measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and, (3) two efficiency measures that address overuse and misuse. Except for the two efficiency metrics, the AQA limited its review to those measures that are currently under review by the National Quality Forum.

The measures in the starter set will lead to a uniform set of measures for ambulatory care that can focus quality efforts and give consumers data they need to make more informed health care decisions. The starter set of measures may be incorporated into performance-based payments as early as next year.

Home Health
As you know, a key part of the Administration's ongoing quality initiative is the public reporting of provider performance on various quality measures. Accordingly, the Home Health Quality Initiative focuses on the public reporting of home health agency performance on 11 quality measures. These quality measures are a subset of the 41 outcome measures included in the Outcome and Assessment Information Set (OASIS), which have been used by home health agencies since 1999. The OASIS is collected by home health agency staff at the start of care, discharge or transfer, at follow up (60 day re-certification), and at the resumption of care.

CMS consulted with HHS' Agency for Healthcare Research and Quality as it identified appropriate quality measures to use for this initiative. The measures were chosen with input from measurement experts and a diverse group of home health professionals, clinicians, and stakeholders. The quality measures include (1) four measures related to improvement in getting around (getting better at walking and moving around using less equipment, getting in and out of bed without help, getting to and from the toilet without help, and having less pain when moving around); (2) four measures related to improvement in meeting basic daily needs (getting better at bathing, getting better at taking medicines, and getting better at dressing the upper part of their body without help, in addition to staying the same at bathing without help); (3) two measures related to medical emergencies (had to be admitted to the hospital and needed emergency medical care); and (4) one measure related to improvement in mental health (being confused less often).

These measures are publicly reported on the Home Health Compare website. Every 3 months the quality information contained in Home Health Compare website is updated. In other words, although the categories of care and the 11 measures of quality remain the same, home health agency scores for each measure are made more current during the scheduled quarterly updates. At the scheduled quarterly update on March 3, 2005, new performance scores for home health agencies were included in Home Health Compare. The scores now reflect how agencies performed during the period from December 2003 through November 2004. The next scheduled update will take place on June 2, 2005.

On February 7, 2005, the National Quality Forum (NQF) announced the endorsement of a set of home health performance measures. CMS plans to update the Home Health Compare website with the NQF endorsed measures shortly.

Question 5:
Pay for performance coordinated with information technology will be an important topic this year. Dr. Brailer and industry experts highlight the critical need for communication between I-T systems in order to successfully capture the benefits of health information exchange and improved quality.

The Administration recently announced the participants for the Medicare physician-group practice demonstration which will look at quality outcomes.

Four of the ten demonstration sites will use I-T technology such as electronic records or physician-order entry systems, yet communication between these systems is never mentioned as one of the intended goals. The Department should ensure that over the 3-year demonstration, performance will also measure whether systems talk to each other.

What are the Administration's strategies to help define and encourage communication between these I-T systems?

Answer:
The goal of the Physician Group Practice Demonstration is to encourage care coordination and investment in administrative structure and process and to reward improvements in health outcomes. Participating physician groups will use a range of technologies and new and existing processes to proactively coordinate services, monitor patients, and improve the quality of care and services delivered to patients. The demonstration does not focus on sharing personal health information among the sites; therefore, interoperability of information technology systems is not necessary for the success of this project.

However, in order to report ambulatory care measures for rewarding quality under the demonstration, an electronic abstraction tool will be used by the groups to report quality measures to CMS in a standard format using a secure transmission environment. The electronic abstraction tool will be able to import data from the groups' information technology systems.

Question 6:
If these I-T systems talk with each other, how would the Agency address issues of privacy?

Answer:
Under the terms and conditions of the demonstration, the physician groups must protect the confidentiality of individually identifiable health information and comply with HIPAA standards governing the privacy and security of electronic transmission of protected health information, as well as the federal Privacy Rule. As noted above, the physician group practices do not share personal health information with each other.

Question 7:
Secretary Leavitt, as you know the President has made quality in health care an important priority. In particular, the President's budget includes significant funding for a variety of quality initiatives including funding for the Quality Improvement Organizations (QIOs), previously known as the Peer Review Organizations. The QIOs were established to serve the following functions: 1) improve the quality of care for beneficiaries; 2) enhance program integrity; 3) and protect beneficiaries.

These functions, although broad in scope, should assist the Administration in improving the quality of care provided to Medicare beneficiaries and hold providers accountable for the care they deliver. There are various areas in which providers are already seeking to improve care, such as nursing homes, home health agencies and physicians' offices. I should hope that the QIOs will work towards the underlying goal of rewarding providers for high-quality care.

Given that the President's proposed Medicare budget includes a substantial increase in funding for QIOs, what are some of the activities the QIOs are involved with and do these activities justify the increased level of spending?

Answer:
Quality Improvement Organizations (QIOs) are a critical part of the Administration's ongoing efforts to improve the quality of care furnished to people with Medicare. As you know, QIOs work with consumers physicians, hospitals, and other caregivers to refine health care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. QIOs also investigate beneficiary complaints about quality of care. Further, QIOs safeguard the integrity of the Medicare Trust Funds by ensuring that payment is made only for medically necessary services.

The statement of work (SOW) defines the contractual work requirements to be accomplished by the QIOs for a 3-year period. The work of the 8th SOW is expected to begin for all QIOs on August 1, 2005. The 8th SOW contract focuses on two domains of activity: (1) assisting providers in developing the capacity for and achieving excellence in care, and (2) protecting beneficiaries and the Medicare Program.

In the 8th SOW, QIOs will support providers in making dramatic improvements in the following areas:

- Clinical performance measures for pressure ulcers, physical restraints and management of depression in nursing homes;
- Acute care hospitalization reduction;
- The use of telehealth in home health agencies;
- Hospitals' adoption of highly effective and efficient quality improvement strategies, such as standardized, effective processes of care;
- Physician office care of patients with chronic disease and preventive services needs, especially those working with
    - underserved populations and physician offices' production;
    - the use and reporting of electronic clinical information; and
    - the adoption of care management such that they can report and improve on a set of expanded clinical and utilization measures that are expected to be part of public and private pay-for-performance (P4P) programs;
- Medication use, including safety and effectiveness; and
- Processes identified through expert medical review of beneficiary complaint cases and wider utilization of dispute resolution (mediation) of quality of care issues.

Question 8:
It is important to provide oversight over programs to determine if the program is using the finances to provide better outcomes. On that note, how does the Department provide oversight of the activities of the QIO to ensure that the functions and goals outlined in the budget are effectively and efficiently accomplished?

Answer:
CMS evaluates Quality Improvement Organizations (QIOs) through specific performance criteria provided in the contract. These criteria are generally quantitative, and enable CMS to determine whether improvement has occurred as a result of the QIO's efforts at the statewide level, and in relation to the assistance, which the QIO has provided, to a subset of providers ("identified participants") that have requested and received more intensive support. Examples of contractual performance requirements in the 8th Scope of Work (SOW) include: (1) statewide and identified participant nursing home performance at specified levels with respect to pressure ulcers and restraints; (2) performance at specified levels by participant home health agencies with respect to acute care hospitalization; (3) 30 percent of physician offices without HIT at the start of the contract using care management; and (4) 90

percent of beneficiaries satisfied with the QIO's process of handling their complaints about the care they received from a provider or practitioner.

Contractor and program evaluation occurs through quarterly reports of results on the performance measures in the contract, as well as at the conclusion of each contract. At the program level, CMS makes comparisons between baseline and re-measurement results with respect to the quality measures that are in the contract, and also compares the results for identified participants versus providers that did not seek intensive QIO support.

Question 9:
As you know, the Medicare Modernization Act directed both MedPAC and HHS to study a number of issues related to physician-owned specialty hospitals – or hospitals that focus on the treatment of certain medical conditions or surgical procedures. MedPAC has conducted extensive research on the issue, and has identified problems with both the physician ownership of hospitals and the way in which Medicare pays these hospitals.

HHS, within 15-months of enactment of the Medicare Modernization Act, was to study and report on the referral patterns of physician owners, the amount of uncompensated care provided at specialty hospitals, and both the quality of care and patient satisfaction in specialty hospitals compared to community hospitals.

Given that the 18-month moratorium on specialty hospitals will expire in June 2005 and Congress must act quickly if it is to make changes, can you share with us your preliminary findings?

Answer:
On May 12, 2005, we released our full report and recommendations. In our report, we outlined four essential steps we plan to take to correct system problems that may unfairly advantage physician-owned specialty hospitals. We considered the complimentary report from the Medicare Payment Advisory Commission (MedPAC) in developing our recommendations. Our key recommendations are as follows:

- *Reform payment rates for inpatient hospital services through changes to the DRG system.* CMS will consider recommending changes to the DRG system in its annual notice about payment changes in the inpatient prospective payment system (IPPS) for fiscal 2007. The agency expects to propose changes in the DRGs that more accurately reflect the severity of a patient's illness in setting the payment level. CMS will also review specific DRGs such as cardiac, orthopedic and surgical DRGs that are alleged to be overpaid and may create incentives for physicians to create specialty hospitals.

- *Reform payment rates for ambulatory surgical centers (ASCs).*
CMS findings noted that orthopedic and surgical specialty hospitals differ significantly from cardiac specialty hospitals which tend to have more inpatient beds, operate emergency rooms and closely resemble community hospitals. Orthopedic and surgical specialty hospitals, the study showed, often concentrate on outpatient care. Physician-owners may seek this designation because payment rates are more favorable than those for ambulatory surgical centers (ASCs). CMS is already planning to reform the ASC payment system to diminish these differences. CMS expects to implement the ASC payment reforms in January 2008.

- *Closer scrutiny of whether facilities meet the definition of a hospital.*
  CMS' study suggests that some specialty hospitals have a high volume of outpatient services, meaning they may in effect not meet the statutory definition of a hospital. CMS will closely review existing specialty hospitals and terminate Medicare provider agreements with those that do not meet the definition. New applicants will also be closely scrutinized and their applications denied if the strict definition is not met.

- *Review of procedures for approval for participation in Medicare.*
  To be approved for participation in the Medicare program, a hospital not only has to meet the definition of a hospital, it also has to meet all of the program's conditions of participation (COPs). The COPs set requirements aimed at assuring a high quality of health care and other standards. Compliance with the conditions is determined through the Medicare survey process or through accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JACHO). CMS will review whether given their limited scope, specialty hospitals meet all the core requirements for a hospital, such as those required by the Emergency Medical Treatment and Labor Act (EMTALA).

A copy of the full report to Congress is available on the CMS Web site.

Question 10:
The administration's budget proposes to save $4.6 billion over 10 years in Medicare spending by expanding the existing inpatient post-acute transfer policy to all DRGs from the current 30. The current Medicare transfer payment policy requires that cases assigned to one of 30 DRGs be paid as transfers when patients are discharged to a post-acute care setting – including rehabilitation hospitals and units, long-term care hospitals and units, cancer hospitals, psychiatric hospitals, children's hospitals, and skilled nursing facilities – or discharged within three days to home health services, are defined as transfer cases when their acute care length of stay is at least one day less than the national average. These cases are paid a daily (per diem) rate, rather than a fixed DRG amount, up to the full PPS rate. Thus, if a patient has a shorter than average inpatient stay, even by just one day, the hospital is paid less than the full DRG rate.

This policy fundamentally weakens the incentives inherent in the inpatient prospective payment system (PPS) structure, and undercuts the basic principles and objectives of the Medicare prospective payment system. The Medicare inpatient PPS is based on a system of averages. Cases with higher than average lengths of stay tend to be paid less than costs while cases with shorter than average stays tend to be paid more than costs. The expansion of this policy makes it impossible for hospitals to break even on patients that receive post-acute care after discharge. Hospitals "lose" if a patient is discharged prior to the mean length of stay, and they "lose" if patients are discharged after the mean length of stay.

A new transfer policy covering all DRGs would effectively penalize hospitals for providing the most appropriate patient care in the most appropriate setting. Further, an expanded transfer payment policy would fail to acknowledge or recognize that in many cases, hospitals' per-case costs include an implicit expectation that post-acute care (PAC) services will be required for a patient upon discharge. For cases in which hospitals do not significantly change their discharge practices involving the use of PAC services, a requirement that they assume such costs would be unfair and arbitrarily penalizing.

Don't you agree that this policy will undermine the ability of integrated delivery systems from providing appropriate care in appropriate settings?

Answer:
No. The Administration believes that expanding the post-acute care transfer policy will reduce incentives to discharge patients prematurely to a post-acute care setting. The goal of the post-acute care transfer policy is to avoid duplicate payments for short-stay cases when the majority of the medical care is furnished at a post-acute care facility.

In the FY 2006 hospital inpatient prospective payment system (PPS) proposed rule, we proposed new criteria that expand the number of Diagnosis Related Groups (DRGs) subject to the post-acute care policy from the 30 to 223. Consistent with the statute, the proposed new criteria are designed to capture those DRGs that include a high volume of discharges to post-acute care and a disproportionate use of post-acute care services.

It is also important to note that the relative weight (an important factor in determining payment) for a DRG under the hospital inpatient PPS is based on the average charge for all cases in the DRG. By reducing the influence that short stay cases have on this calculation, the relative weight of the DRG may actually increase resulting in higher payments for patients that stay in the hospital for longer periods of time. In this way, the post-acute care transfer policy works to better target Medicare's payment based on the resource costs hospitals incur treating patients.

Question 11:
Mr. Secretary, as I understand it, a thematic of your Medicaid proposal is to expand access by closing loopholes. Expanding access and curtailing the misuse of federal Medicaid dollars is a concept that I support.

Can you elaborate on some of the "loop holes" you propose closing? Specifically, can you comment on the various ways that states have used Intergovernmental Transfers to maximize federal resources and the ways in which they spend those federal dollars? Do you make a distinction between states spending IGTs dollars on medical services that may not be covered by Medicaid and spending for non-medical purposes? How should we work with states that are using Medicaid dollars brought into the state by IGTs who are relying on these dollars to address the medical needs of vulnerable populations and may be facing budget shortfalls?

Answer:
Medicaid is a partnership between the federal government and the states. Over the last two decades, states have developed innovative ways of enhancing federal matching dollars.

CMS is responsible for strengthening financial oversight and ensuring payment accuracy and fiscal integrity in the Medicaid program. The statute requires that federal matching funds must be a match for real Medicaid expenditures for Medicaid beneficiaries. At the federal level, our primary role is to exercise proper oversight and review of state financial practices and to provide guidance and support for states' efforts to ensure program and fiscal integrity. While we have made substantial progress in helping states identify and reduce improper payment mechanisms, we are also strengthening Medicaid federal financial management activities.

Since August 2003, as part of the review process for state requests for changes in payment methodologies through State Plan Amendments (SPAs), CMS has been examining information from states regarding detail on how states are financing their share of Medicaid program costs. This examination is applied consistently and equally to all states under the SPA review process. New SPA proposals will not be approved until CMS has determined that the state is securing appropriate non-

federal funding to finance its share of its Medicaid program or has agreed to terminate financing practices that do not appear consistent with the statutory federal-state financial partnership.

During that SPA review process, CMS has discovered that some states utilize financing techniques that do not comport with the statutory requirements that establish the federal-state partnership. Specifically, CMS has discovered that several states make claims for federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the "guise" of intergovernmental transfers (IGTs), state and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the federal taxpayer.

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 (even though 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 actual Medicaid program costs than the federal statute authorizes.

Through our state plan amendment reviews, we have determined that in some instances states are using Federal Medicaid dollars to supplant the required state share for their Medicaid programs, and in other instances are re-directing the Federal Medicaid dollars to pay for care associated with non-Medicaid uninsured populations. Once the effective Federal share (FMAP) is raised through various financing and transfer mechanisms, however, it becomes impossible to determine what items and programs are now being financed with Medicaid dollars. Federal dollars are supplanting state dollars and the Medicaid program is unquestionably paying for things that it should not be paying for. A Federal dollar "recycled" to supplant the non-Federal Medicaid dollar means that the non-Federal dollar is available for spending for other state purposes (including traditional state responsibilities such as roads, bridges, foster care or schools).

While some have argued that there are significant benefits from this "redirected" spending, particularly spending on behalf of the uninsured population, it is important to note that we are working hard to help the states find creative ways to meet budgetary constraints and help the uninsured while still contributing the appropriate non-Federal share of Medicaid expenditures, as defined by the state-Federal partnership articulated in the Social Security Act.

CMS remains committed, however, to working closely with states to develop and implement programs that use "real" dollars to pay for the costs of caring for the uninsured population. Since the beginning of this Administration, we have worked to develop demonstration programs that help states address the plight of uninsured Americans. Most recently, for example, we approved a demonstration in the Commonwealth of Massachusetts that permits disproportionate share hospital (DSH) payments to be re-directed to pay for the costs of care of the uninsured populations outside of the hospital setting. The State will also be permitted to use these "re-directed" DSH dollars to eventually purchase health insurance coverage for some of the uninsured population in the State. By fully embracing the Federal-state partnership, CMS and the Commonwealth were able to create a demonstration program, which will help reduce the rate of uninsured in Massachusetts. Allowing the Commonwealth to invest up to 10 percent of the Safety Net Care Pool (SNCP) for infrastructure and capacity building will now enhance the community provider network by increasing access to quality health care.

We believe that making it easier for people to obtain affordable health care coverage is key to addressing the problem of the uninsured in this country. We are very interested in working with states such as Massachusetts to find creative approaches using real state dollars matched with Federal dollars to make coverage more affordable for low-income Americans.

Question 12:
As you know, Medicaid was established 25 years before the passage of the Americans with Disabilities Act (ADA) and long before the notion of aging-in-place or of community-based services and supports was widely known or well established. Medicaid continues to have a funding bias in favor of costly institutional care over less expensive and more desirable community-based care.

Institutional and nursing home services are among Medicaid's mandatory services, but the great variety of in-home services required by people with disabilities who wish to and who could remain in their own homes and communities are either optional or are provided as waiver services. The President's New Freedom Initiative promotes community-based care options. Yet, the need remains to make fundamental reform to the Medicaid statute to ensure that no institutional funding bias exists and that people with disabilities truly can choose to live in their communities.

I appreciate that the President's proposed Medicaid budget includes funding for the Money Follows the Person Rebalancing Demonstration, several other smaller demonstration projects to support people with disabilities in community-based care, as well as a change in eligibility status for individuals being discharged from hospitals. Do you think these demonstration projects and eligibility changes are enough? Do you believe it would make greater fiscal and programmatic sense to seek a change in the statute to more cost-effectively use Medicaid to fund desired community-based services?

Answer:
To ensure Medicaid can serve more beneficiaries at a lower cost, the institutional bias in Medicaid long-term benefits resulting from lack of beneficiary control must be addressed. CMS has been working hard to promote consumer choice and home- and community-base services over institutional care when it is appropriate for beneficiaries. Both consumers and states are very receptive to this approach, and the evidence from the programs developed so far is that it is a win-win effort.

Although it is not a recent development, the introduction of the Independence Plus waiver template in 2002 gives states tools to create programs that will allow people with disabilities and their families to decide how best to plan, obtain and sustain community-based services, placing control into the hands of the people using the services.

The electronic templates provide guidance to states on how to develop these programs within existing federal requirements using a streamlined application process, which will ultimately result in faster federal approval of state proposals. Similar programs have been shown to promote cost-effective and flexible solutions for care while meeting the individual needs of people receiving services.

More recently, CMS has approved several ground breaking waivers —Vermont and Florida among them—that will afford Medicaid enrollees substantially more options and flexibility in how they receive services while providing them the necessary support to make informed choices.

The progress we have made with the President's New Freedom Initiative (NFI) also points us in the right direction. The President has demonstrated continued commitment to the *New Freedom Initiative* by authorizing approximately $385 million in FY 2006 and $2.2 billion over 5 years for the following:

Money Follows the Person Rebalancing Initiative

- This demonstration finances the full cost of a package of home and community-based Medicaid services for one full year for individuals who transition from institutions to the community and supports states in rebalancing their long-term support systems.
- The proposed budget authorizes $350 million in FY 2006 and $1.75 billion over 5 years.

Home and Community-Based Care Demonstrations

- Respite services to caregivers of adults with disabilities. ($7 million in FY 2006 and $134 million over five years)
- Respite service to caregivers of children with severe disabilities. ($1 million in FY 2006 and $23 million over five years)
- Community-based services for children residing in psychiatric residential treatment facilities. ($10 million in FY 2006 and $170 million over five years)

Spousal Exemption

- This proposal protects Medicaid coverage of eligible spouses of individuals who participate in 1619(b), a Social Security work incentive program that provides some protection for SSI beneficiaries that have concern about going to work and losing their Medicaid coverage.
- Under section 1619(b) of the Social Security Act, an individual who receives SSI and goes to work can retain their Medicaid coverage even after they no longer receive SSI payments.
- Currently, however, if an individual is Medicaid eligible and his or her spouse participates in 1619(b), the spousal earnings can cause the Medicaid beneficiary to lose coverage.
- The President's Budget proposes $17 million in FY 2006 and $102 million over 5 years.

Presumptive Eligibility for Home and Community-based Care Services

- This proposal establishes a State option of allowing Medicaid presumptive eligibility for individuals being discharged from the hospital to the community.
- The proposal has no cost to the Federal government.

The President's proposals pave the way for the elderly and individuals with disabilities to have a real opportunity to direct available Medicaid funding towards living in settings of their choice. This builds on the successes we have seen in states who have taken creative steps to rebalance their long-term care systems. The FY 2006 legislative package for NFI is a logical next step to take towards making a difference in where the elderly and individuals with disabilities receive their care.

Question 13:
As you are aware Senator Kennedy and I have re-introduced the Family Opportunity Act –legislation that would give States the option of expanding Medicaid coverage to children with significant disabilities whose family income is too high to qualify them for Medicaid.

Parents of these children must currently turn down jobs, turn down raises, turn down overtime, and are unable to save money, so that they can stay in the income bracket that qualifies their child for SSI or Medicaid.

Last year, during negotiations with the Administration and the House this legislation was linked with the "Money Follows the Person" legislation, which I am pleased to see the President has proposed to include in his fiscal year 2006 budget.

I was somewhat disappointed to learn that the President's budget did not include funding for the Family Opportunity Act. Does the Administration support expanding Medicaid coverage to children with significant disabilities whose parents' incomes place them above the financial threshold for Medicaid eligibility? What incentives are being offered to States in this budget to expand coverage of children with severe disabilities and keep their parents working?

Answer:
Last year, we worked with Members of Congress in support of a legislative package that included the Family Opportunity Act – a proposal that would allow families with income up to 250 percent of the Federal poverty level to "buy into" Medicaid to cover the health care costs of their disabled children. The legislative package also included the Money Follows the Person demonstration initiative.

The FY 2006 Budget includes the Money Follows the Person demonstration and also includes home and community-based care demonstrations for respite services for caregivers of children with a substantial disability and caregivers of adults with disabilities. The budget also includes a proposal to provide home and community-based services to children with serious mental illnesses who would otherwise reside in Psychiatric Residential Treatment Facilities (PRTFs.) These proposals promote home and community-based care options for children and adults with disabilities and further the use of the home and community-based services waiver program.

I look forward to working with Congress this year on these important proposals.

Question 14:
In Iowa, there are 371 public school districts, as well as the Iowa Braille and Sight-Saving School and the School for the Deaf, that, since March of 2001, have been able to seek reimbursement from Medicaid for covered medical services provided to Medicaid-enrolled children with special health care needs. As you know, I am an advocate for children with disabilities and support all efforts to improve health care for children.

I know as well that CMS has done a tremendous job of ensuring the integrity of the Medicaid program by working with states to make certain that Medicaid-enrolled children with disabilities and other special health care needs are receiving appropriate school-based health services such as speech and occupational therapies. CMS also works to keep administrative costs for these services to a minimum, and attempts to provide appropriate federal and state oversight of these services. I am also pleased to see that the Administration is clarifying some its school-based health policies by proposing to put them in regulation.

Do you expect any of the payment reforms being proposed to affect the provision of school-based health services to Medicaid-enrolled children with disabilities and special health care needs? Could you comment on improvements that have been made with regard to federal oversight of billing for school-based health services? In 2000, the GAO reported to this committee that there was a need to provide guidance to and monitoring of allowable administrative activities funded by Medicaid. Has there been a reduction in administrative cost billing by school systems since that time?

Answer:
As the Committee is aware, CMS performs continuous reviews of all State Plan amendments as they are submitted by our state partners to ensure conformity with Federal Medicaid requirements, including those that pertain to funding and reimbursement. We agree with the Chairman that it is of critical

importance to make certain that children with special health care needs receive necessary Medicaid services in school-based settings.

The only payment reform proposed in the President's Budget that could affect school-based services is the requirement that public providers be paid at cost. As a matter of policy CMS has been requiring school-based services rates to be cost-based, so it would only impact schools to the extent that they have older payment methodologies that do not meet this requirement.

The other policy that impacts schools is CMS enforcement of the rules regarding Certified Public Expenditures (CPEs). In order for schools to fund the non-Federal share of services through CPEs the rates must be cost-based and reconciled annually to actual cost at the level of the provider. We have found that the rates paid to schools are often not cost-based and often there is no process in place for the required annual reconciliation. States have indicated that a reconciliation process is administratively difficult for schools (which, in turn, is causing some states to reconsider how they fund school-based services).

In May 2003, CMS issued the "Medicaid School-based Services Administrative Claiming Guide" to provide the additional guidance needed with regard to administrative claiming in this setting. There has been an overall decline in claims for school-based services (17.5 percent in FY 2002 to 12.9 percent in FY 2003). However, these state reported data are not adjusted by CMS; they may be affected by increasing or decreasing claims for prior periods; and they may be affected by delays in states' reporting. However, together with the Department's Office of the Inspector General, CMS will continue to do financial management reviews to assess risk in each of our regions where there is significant school based claiming.

Question 15:
As you know, the President's budget included a proposal for outreach and enrollment in Medicaid and SCHIP for eligible children. I support this effort. Various reports conclude that anywhere from 4 to 6 million children remain uninsured, despite being eligible for Medicaid or SCHIP. This is a serious issue that deserves our thoughtful attention.

I also support the provision in the President' budget which would accommodate the federal share of the increased costs that would be associated with a broad outreach effort.

However, the proposal, as I have seen it leaves several issues open. As you know, a number of states face SCHIP shortfalls, while other states have surpluses.

I would be interested in learning how the Administration plans to address this issue in the context of an accelerated reauthorization?

Answer:
Under current law, SCHIP is authorized and appropriated through FY 2007. The Administration seeks to reauthorize the program early at current law levels, and is specifically proposing to better target SCHIP funds in a more timely manner. The proposal accomplishes this by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year.

States have submitted SCHIP estimates to us for FY 2005 that indicate that they only anticipate spending $5.3 billion of their available allotments. Once I have completed the redistribution of FY 2002 funds to meet the needs of the states that may otherwise have experienced shortfalls in FY 2005, there will be more than enough money to meet the needs of all states for their current enrollees, as well as to cover new children who we want to find through outreach efforts.

In addition, there are sufficient funds in the SCHIP program to meet current state needs, as well as to cover additional children that would be enrolled as a result of the comprehensive outreach efforts that President Bush has proposed through the Cover the Kids campaign. Therefore, if the President's reauthorization and outreach proposals are passed, we estimate that there will be plenty of funding in the system to cover these children.

Question 16:
Secretary Leavitt, you spoke of optional Medicaid beneficiaries being "healthy" and not needing comprehensive services. But more than half of all nursing home residents are optional Medicaid beneficiaries, and Leavitt's comments raised the spectre that they will be treated differently than other Medicaid residents. The only difference between the two is that optional beneficiaries have incomes above 74 percent of the poverty level.

You and the Administration have talked about giving states more "flexibility" in how they run their Medicaid programs. We envision a replay of 2003 when we couldn't get Administration officials to agree on whether federal protections, including the Nursing Home Reform Act, would still apply to the vast majority of nursing home residents. What would happen to NHRA standards and enforcement? Spousal impoverishment? Prohibitions on making families pay for parents' nursing home care? Requirements that optional and mandatory beneficiaries receive the same type and level of services?

Answer:
In the FY 2006 budget, the Administration proposes to provide states with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government.

A modernized Medicaid system will give states greater flexibility without the need for burdensome waiver applications. Long-term care reforms will build on successful programs that use consumer direction and home- and community-based care to improve satisfaction and lower costs. A modernized Medicaid system will continue to grow at a robust rate to accommodate increases in health care spending.

We look forward to working with Congress on modernizing the Medicaid program.

Question 17:
Additionally, you have talked about ending the institutional bias of Medicaid and paying for more home care ("which is cheaper"). The GAO report showed how poor federal oversight has been of home and community-based services, although GAO found that 70 percent had problems, including failure to provide adequate services. Is the Administration prepared to institute federal regulations governing quality and state oversight of home and community-based services if it expands Medicaid coverage of them?

Answer:
The Administration has consistently worked to ensure that Home and Community Based Services (HCBS) waiver programs allow people the independence to stay in their own homes while receiving quality services and supports in a community setting. In the last three years, CMS has launched a series of quality initiatives aimed at improving federal oversight and providing assistance to state agencies. Because states have the first-line responsibility for administering the waiver program and assuring health and welfare of its waiver participants, CMS focuses its attention on assisting states in their quality management activities and in Federal oversight.

The continuous Federal oversight process begins with CMS' s review of the waiver application when CMS determines if the state has designed the program to include a quality management strategy. Over the life of each waiver, CMS and the state have ongoing conversations, onsite visits and the states submit evidentiary reports to CMS. When the waiver is due to expire and can be renewed, CMS Regional Offices review evidence from the states that the states are meeting the quality management goals. If the Regional Office determines from the information the state provided that the assurances are substantially met, then the Regional Office recommends the waiver's renewal.

Over the last two years, CMS has collaborated with associations representing the agencies that administer the Home and Community Based programs – state Medicaid agencies, agencies for the developmentally disabled, and agencies on aging – to develop the *HCBS Quality Framework* document. This document provides a uniform national format, or framework, for the discussion between CMS and the states about the key components of a state's quality management (QM) system. The *Framework* has now been incorporated into the revised draft waiver application, which for the first time, asks states to develop, describe and report to CMS on their quality management strategy. The states have considerable flexibility in the design of the QM strategy, but the state's strategy must at a minimum provide the state and CMS with evidence that the required statutory assurances are met. We are pleased to report that the revised application is being well received by states; CMS plans to conduct a pilot test and evaluation of the application in the upcoming months and to develop it as a web-based tool.

In addition, CMS has provided extensive technical assistance to states to help them develop their quality management (QM) strategies. This assistance has been provided both by CMS staff and by our National Quality Contractor. The assistance provided is customized to meet states' individual needs. CMS also provides technical assistance through the production of tools, workbooks and guidance documents, and "promising practices" that focus on a variety of quality topics and are disseminated to all states for their use.

Additionally, CMS sponsors an annual conference targeted to Real Choice Systems Change, Aging and Disability Resource Center, Ticket to Work Medicaid Infrastructure, and Direct Service Community Workforce grantees; staff from State Medicaid, Health, Mental Health, Developmental Disabilities, and Aging Agencies; staff from advocacy organizations; researchers; providers; state legislators; Independent Living Centers; and consumers. These conferences showcase the many efforts underway to improve services and supports for individuals with disabilities and long-term illness, and facilitate the sharing of lessons learned across states.

In total, these steps build on our quality efforts and address the concerns in the GAO report. The home and community based services oversight role is designed to ensure the Home and Community-Based services that are provided are delivered by a trained workforce in accordance with each individual's needs; we have found these to be the essential building blocks of quality services no matter where they

are delivered. This is a critical matter that we continue to diligently focus on as we work to expand opportunities for individuals to receive care in settings of their choice.

Question 18:
It appears that the cap on funds for state administration would affect states' ability to conduct their survey and certification programs. Is the Administration proposing a reduction in effort in the Nursing Home Quality Initiative?

Answer:
The administration is not proposing a reduction in effort in the Nursing Home Quality Initiative. The quality of care provided to nursing home residents is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). Ensuring the safety of beneficiaries and the quality of care provided in health facilities are two of CMS most critical responsibilities.

In November 2002, HHS and CMS launched the national Nursing Home Quality Initiative (NHQI). The initiative provides new comparative information to consumers and resources to facilities all aimed at improving nursing home quality of care. Since 2002, the number of measures has been expanded from 8 to 15, reflecting improvements in quality measurement and endorsement by the National Quality Forum. Over the past two years, significant improvement has been achieved in a number of the publicly reported quality measures.

The on-going CMS nursing home survey and certification activities are also part of the NHQI, and have a dedicated funding stream through the Survey and Certification budget. The FY 2006 budget request is $260.7 million, $2 million more than the 2005 level.

Question 19:
I appreciate the Administration's emphasis on healthy marriages. As you know, the correlation between a healthy two-parent family and a child's emotional and economic well being is indisputable.
I also appreciate the fact that many low-income adults want to get married and that many single mothers are in contact with the father of their children at the time they give birth to these children.

I understand that one of the allowable uses of marriage promotion funds is pre-marital education and marriage skills training for couples interested in marriage. However, I am informed that for some couples, these pre-marital education courses do not lead to marriage. I am told that as many as 15% of couples who enter into pre-marital counseling choose NOT to get married.

Can you comment on whether or not you believe it is a positive or desirable outcome if couples entering pre-marital counseling elect not to marry?

Answer:
I believe it is desirable for couples interested in marriage to seriously discuss and plan how they will deal with the variety of critical issues that face married couples. Pre-marital education and counseling help couples recognize that it is important to understand each others' perspectives on marriage expectations, children and parenting, spiritual beliefs, role relationship, sexual relationship, family and friends, financial management, leisure activities, and issues of personality, communication and conflict resolution before they marry. Pre-marital education and counseling enable couples to make informed choices, but are not intended to convince people that marriage is a good thing.

These services also help people understand that skills matter in forming and sustaining healthy marriages - just as skills matter to good parenting. Healthy marriage programs do not push people into marriages, but help them understand how healthy relationships and marriages work, assess their own relationships realistically, and gain the skills and knowledge that have been shown to be associated with healthy marriage.

Each person must consider whether or not they should get married for themselves, and government will not interfere in the private decision-making of individual couples. The objective is to help those who have chosen marriage to have access to programs and services that will allow them to build the knowledge and skills that will enable them to succeed at marriage. If some couples participate in pre-marital education training and ultimately decide not to get married because they come to learn that they are either not ready for marriage or some aspect of their relationship is flawed or not healthy, making marriage a poor choice, I believe that is a positive outcome.

Pre-marital education and counseling will also help people form healthy, respectful relationships and marriages that reduce the risk of abuse and violence. For example, sessions may bring to light unhealthy behaviors that couples come to understand will affect the likelihood of sustaining a healthy marriage. This may include types of abusive behaviors or fighting that a trained educator or counselor or other professional can help them address together, or individually, as appropriate given the circumstances. Couples may postpone getting married while they work on correcting and improving these behaviors. Others may decide it is in their best interests not to marry each other.

Healthy, long-lasting marriages that provide the best environment for raising children do not happen just by chance. Successful couples in healthy marriages are able to effectively address and resolve conflict and often develop strong listening and communication skills and these are skills which can be learned. Individuals contemplating marriage - including youth and young adults - can benefit greatly from learning ahead of time about how healthy relationships are formed and nurtured, what healthy marriages are, and what it takes to make them successful.

Question 20:
Secretary Leavitt, you spoke of optional Medicaid beneficiaries being "healthy" and not needing comprehensive services. But more than half of all nursing home residents are optional Medicaid beneficiaries, and Leavitt's comments raised the spectre that they will be treated differently than other Medicaid residents. The only difference between the two is that optional beneficiaries have incomes above 74 percent of the poverty level. You and the Administration have talked about giving states more "flexibility" in how they run their Medicaid programs. We envision a replay of 2003 when we couldn't get Administration officials to agree on whether federal protections, including the Nursing Home Reform Act, would still apply to the vast majority of nursing home residents. What would happen to NHRA standards and enforcement? Spousal impoverishment? Prohibitions on making families pay for parents' nursing home care? Requirements that optional and mandatory beneficiaries receive the same type and level of services?

Answer:
In the FY 2006 budget, the Administration proposes to provide states with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government.

In providing this flexibility to states, the Administration does not seek to preempt any current provisions or laws that protect nursing home residents, which may include the Nursing Home Reform Act.

A modernized Medicaid system will give states greater flexibility without the need for burdensome waiver applications. Long-term care reforms will build on successful programs that use consumer direction and home- and community-based care to improve satisfaction and lower costs. A modernized Medicaid system will continue to grow at a robust rate to accommodate increases in health care spending.

We look forward to working with Congress on modernizing the Medicaid program.

The Honorable Max Baucus
Ranking Member, Senate Finance Committee

Question 1:
The President's FY 2006 budget announces CMS intent to continue the Administration's policy of making the savings from risk adjustment budget neutral with respect to plans in 2006. The budget also proposes to begin phasing out this policy beginning in 2007 to allow savings to accrue to the Medicare program. What is the precise schedule for phasing out the policy beginning in 2007? What is the Administration's justification for not allowing risk savings to accrue to Medicare earlier?

At the hearing, Secretary Leavitt stated that part of the intent is to ensure plans participate in Medicare Advantage. Please explain why plans need this policy to participate, especially given increased payment rates under MMA?

Answer:
CMS did not phase out budget neutral risk adjustment earlier than 2006 to ensure stability in the Medicare Advantage program. The President's 2006 Budget included a phase out schedule that CMS is currently implementing. This schedule is as follows: in 2006 - 100% of plan savings will be redistributed back to plans, in 2007 - 60% will be redistributed, in 2008 - 45% will be redistributed, in 2009 - 30% will be redistributed, in 2010 - 15% will be redistributed, and in 2011 plans will no longer share in risk adjustment savings.

By slowly phasing out budget neutrality of risk adjustment, the policy in the 2006 Budget balances the need to create a stable environment for plan participation in 2006, the first year of the new competitive system for Medicare Advantage plans, and to refine payments fully for the health status of beneficiaries.

Question 2:
As the new Medicare Part D program gets underway in 2006, Congress will be deeply interested in knowing as much as possible about how the program functions overall, about the scope and quality of the benefit and how well it works for different constituencies, such as dual-eligibles (those beneficiaries eligible for both Medicare and Medicaid) and rural beneficiaries. While CMS can be expected to provide some of that information, Congress will rely on analyses from congressional agencies, as well as public experts from the research and beneficiary communities, to assess the drug benefit.

To properly assess the drug benefit, a new and very important level of transparency will be necessary from CMS. By transparency, we are referring to data—such as prescription claims as well as cost sharing and premium information—that can be aggregated across plans, geographic areas, and nationally.

What are CMS's plans to share program data with Congress, researchers and the public so that the scope and quality of the benefit can be assessed?

Answer:
CMS plans to share some of the data such as cost sharing and premium information up front with beneficiaries in order for them to make the best decision about plan enrollment. Comparative information on plans such as monthly premiums, cost sharing, quality and, if available, performance and

customer satisfaction surveys will be provided to beneficiaries to enable them to choose the prescription drug plan that best fits their needs.

CMS will also gather program data about the drug benefit. We want to make that data available as appropriate to Congress, researchers and the public in a manner that protects beneficiary privacy and confidentiality. We are developing a framework that will guide our data collection and release efforts with the goal of creating information resources that would promote enhanced quality and efficiency of care and the clinical evaluation of the impact of using specific products. We are talking with private health insurance plans that are considering similar goals to ensure that our data development efforts result in compatible databases to enable researchers to evaluate impacts and outcomes across several populations.

Question 3:
Under the "Essential Hospital" provision of the MMA, selected hospitals may be required to operate as "in-network" providers for all Regional PPOs covering their services areas. Will hospitals that own and operate a local Medicare Advantage plan also be required to participate as "Essential Hospitals" in regional PPO networks—in other words, in the networks of potential competitors? How will CMS regulate this?

Answer:
A hospital that is designated an "essential hospital" will not be required to participate in regional PPO networks. "Essential hospital" designation means that if such a hospital treats the members of a non-contracting MA organization's plan, additional CMS payment is potentially due such a hospital. MA organizations are required to pay non-contracting providers the amount that would otherwise be payable under original Medicare. An essential hospital would be paid an additional amount, up to 101% of its actual costs, where the costs of treatment exceed the amounts payable under original Medicare for inpatient services provided to MA regional plan enrollees. Each MA regional plan will need to designate its own unique set of "essential hospitals." Designation by one MA regional plan of a specific hospital as "essential" has no bearing on whether that hospital is "essential" to another MA regional plan.

The MMA specified that $25 million a year be made available to "essential hospitals" that treat regional Medicare Advantage plan enrollees. CMS will be working closely with Medicare Advantage plans to ensure that good faith efforts have been made in contracting with essential hospitals.

Question 4:
In 2006, Medicare beneficiaries will face many changes to the program, including a new Part D benefit and more Medicare Advantage options. How will CMS ensure beneficiaries are informed about the details of the new options, such as the late enrollment penalty under Part D and the lock-in aspect of Medicare Advantage? In areas where Medicare plans have not been available, such as Montana, would you be willing, under your discretionary authority, to allow "Special Election Periods" for beneficiaries enrolling in Medicare Advantage plans, until beneficiaries are accustomed to the new options? Enrollment flexibility may be particularly helpful in areas served by only one plan.

Answer:
In many of our direct mailing and education materials to beneficiaries including the *Medicare & You 2006* handbook, we highlight the urgency of applying now for the drug benefit rather than waiting because a higher premium may be applied. Before the enrollment period ends on May 15, 2006, our outreach and education campaign will encourage beneficiaries to enroll in order to avoid paying more

for Part D coverage. Those individuals who are dual eligible beneficiaries, in the Medicare Savings Program, receiving SSI, and those who applied and qualified for the low income subsidy will be enrolled by CMS into Medicare drug plans if they do not enroll on their own. The harder to reach and potentially more vulnerable population will not have to worry about the late enrollment penalty (unless they elect to opt out of enrollment completely).

We are implementing a significant community-level outreach effort working with and through organizations in the community with a shared interest in helping people with Medicare understand their options and enroll in a plan that meets their needs. CMS has increased funding for the State Health Insurance Assistance Program (SHIP). Under this program, CMS provides funds to state programs, and they in turn fund programs that provide individualized counseling to beneficiaries on their choices for Medicare Advantage (MA) among other Medicare topics. Beneficiaries can also visit our consumer website, www.medicare.gov, which contains comprehensive information about the new drug coverage and Medicare Advantage plans. The *Medicare & You 2006* handbook will also provide information on the lock-in aspect of Medicare Advantage. We have increased the number of customer service representatives helping beneficiaries at the 1-800-MEDICARE helpline. This helpline is available 24 hours a day, 7 days a week, to answer questions from beneficiaries, including questions on specifics of the new benefits. We will also engage in extensive local outreach to beneficiaries through our partners and other community-based organizations with a particular focus on vulnerable populations with information access issues. Finally, a national advertising campaign will help to ensure that people know where to access information when they need to make a decision.

With respect to election periods for beneficiaries to choose to enroll in an MA plan, the Medicare law provides for two different and largely overlapping enrollment periods in 2006 for beneficiaries to enroll in an MA plan. The first is the annual election period that runs from November 15, 2005 through May 15, 2006 and the second is the open enrollment period that runs from January through June, 2006, providing beneficiaries with two opportunities to make MA plan election choice. The effect of these provisions is that beneficiaries can enroll in an MA plan for the first time beginning November 15, 2006 (with enrollment effective the following January 1) and during the first six months of 2006. We believe this time period to elect an MA plan will give beneficiaries a reasonable amount of time to become informed about their MA options and elect to enroll in an MA plan if they so choose and that using our authority for special enrollment periods should not be necessary.

Question 5:
As you know, the proposed Part D rule stated that prescription drug plans PDPs would not be able to use differences in cost-sharing to steer beneficiaries to mail-order pharmacies, away from local retail pharmacies. But the final rule seems to reverse this position, allowing PDPs to charge Medicare beneficiaries lower cost-sharing at mail-order than retail pharmacies. Has the Administration changed its position on this issue? If so, why?

Answer:
The MMA's "level playing field" provision in 1860D-4(b)(1)(D) prohibits Medicare drug plans from requiring beneficiaries to use mail order pharmacies. It allows Medicare beneficiaries to receive extended supplies of drugs at retail settings, but they must pay "any differential in charge" between retail and mail order. Our understanding of the statutory language is that the beneficiary is allowed the choice, which may entail higher costs, but the plan (and the government) pay what we would have paid if the drug were delivered in the lowest-cost setting. We also understand that it is important to maintain the personal contact that patients have with their local pharmacist, from whom they can receive counseling and answers to their health questions.

The statutory term "charge" is actually quite general and can encompass a variety of individual charges that affect both total cost and how much a beneficiary pays at the pharmacy counter. For example, the price of the drug (its ingredient cost) often varies between retail and mail order, as does the dispensing fee. Mail order facilities are highly automated and generate much lower per-unit dispensing fees. It is common in the commercial market today for plans to offer lower cost-sharing on drugs provided by mail order. The proposed rule did not specifically address differences between mail order and retail cost sharing. The final rule did address the situation by allowing plans to charge "any higher cost sharing applicable" to retail, compared to mail order. After publishing the final rule, CMS also issued additional guidance to plan to instruct them how this level playing field rule should be reflected in their contracts with pharmacies. As part of that guidance, CMS encouraged plans to allow pharmacies the opportunity to match the mail order rate completely in the retail setting, which would result in no cost sharing difference for the beneficiary. Barring that, under CMS guidance, pharmacies could partially match the mail order rate, which would require the beneficiary to make some extra payment to receive an extended supply at retail.

We believe the final rule, coupled with the guidance, reflects the statutory intent that plans be able to provide, and beneficiaries to receive, their drugs in the lowest cost setting, but also allows beneficiaries the opportunity to receive extended supplies at retail.

Question 6:
As you know, the MMA mandated that prescription drug plans (PDPs) meet the TRICARE standard for pharmacy access, which stipulates that PDPs must have an in-network retail pharmacy within a maximum distance of specified percentages of rural, urban and suburban beneficiaries. This is important, as without an in-network pharmacy, Medicare beneficiaries will be forced to pay higher cost-sharing for their drugs. But as I understand from the final Part D rule, CMS will allow PDPs to offer a pharmacy access standard less stringent than that of TRICARE, by designating pharmacies within the PDP's network as "preferred" and "non-preferred." Under TRICARE, cost-sharing is uniform for all in-network pharmacies. By allowing the designation of pharmacies within its network as "preferred" and "non-preferred" (and, accordingly, allowing differential cost-sharing), CMS ignores the TRICARE standard, Section 1860D-4(b)(1)(A) of the MMA, and the MMA report language, which states, "the minimum in-network pharmacy for each plan offered by a PDP or MA plan in a geographic area must provide access to pharmacies that is not less restrictive than the TRICARE access standards."

Will you please clarify your understanding of the law as it relates to pharmacy access, and explain why CMS appears to have disregarded the intent of the law in this matter?

Answer:
I want to assure you that the Department and CMS are committed to timely and full implementation of the prescription drug benefit under the MMA and to providing drug coverage through Medicare with all the beneficiary protections contained in the law.

The MMA has several related provisions that are important to note here. First, the law requires plans to construct a broad network of retail pharmacies that provide convenient access to Medicare beneficiaries. In the CMS regulation, we defined this convenient access standard as per the TRICARE standard: in urban areas, the network must be broad enough so that 90 percent of beneficiaries live within 2 miles of a network pharmacy; for suburban areas, 90 percent must live within 5 miles, and for rural areas 70 percent must live within 15 miles. We believe that this standard will serve residents of cities and rural areas very well and will generate broad participation by pharmacies.

Second, the law allows any pharmacy willing to meet a plan's terms and conditions to join that plan's network, so even if a plan does not need to include a particular pharmacy in order to meet the convenient access standard, the pharmacy has an opportunity to participate. Finally, the law also allows plans to reduce cost sharing for in-network pharmacies below the level otherwise required, creating the possibility of having a network that features preferred and other pharmacies.

We believe that our regulations properly reflect these three provisions and will provide convenient access to all Medicare beneficiaries.

Let me address your concern that preferred pharmacies could negatively impact beneficiaries. In practice, there will be several constraints on the plans' use of this preferred pharmacy option. To start, CMS will thoroughly review the plans' proposals for preferred networks to make sure that no geographic discrimination will occur. For example, CMS would not allow plans to construct a preferred network that favored cities over rural areas or that concentrated preferred pharmacies in certain parts of a state. This review is consistent with a general rule in the Medicare drug benefit that no plan feature can be designed with discrimination in mind, to either encourage or discourage certain groups of beneficiaries from enrolling. Finally, there is a significant constraint on the cost sharing differential that plans can establish to encourage people to use their preferred pharmacies. In their bids to CMS, plans have to show that their co-pays or co-insurance percentages during the drug benefit's initial coverage phase average out to 25 percent of the cost of the drugs. This average covers the plans entire expected utilization, so it includes not just generic, preferred brand and non-preferred brand co-pays but also those co-pays in preferred and other pharmacies. This means that when a plan features lower co-pays at preferred pharmacies, this would tend to lower the average. Mathematically, there are strong limits on how big a co-pay difference the plan can set up and still meet that 25 percent average overall.

I am confident that through our regulations and our program oversight we will be able to provide convenient pharmacy access as prescribed by the MMA.

Question 7:
In 1997 Congress passed the Critical Access Hospital (CAH) legislation, based on a Montana demonstration project. We also passed the "Flex" grant program, to help hospitals convert to CAH status, develop rural health networks and improve quality. I worked to get Flex funding in 1998, and the initiative has been funded ever since. While the Flex grant was intended to help hospitals convert to CAH status, the law also stated that these funds should be used to improve health care quality in rural areas. Given all of the attention to 'paying for quality' these days, don't you think it's short-sighted to be cutting initiatives that help improve quality?

Answer:
Addressing the needs of rural America has been, and continues to be, a top priority for this Administration and for me personally. The Medicare Modernization Act (MMA) proved to be one of the most generous packages for rural providers, bringing an estimated $25 billion dollars of needed relief. The new provisions in the bill directly address the concerns that had been raised about continued access to care for beneficiaries residing in rural areas and appropriate payment for rural providers. I look forward to working with you to use this broad array of programs and funding increases to provide the best possible health services for rural beneficiaries.

Currently, rural residents tend to have more difficulty accessing health care and have poorer health outcomes than their urban counterparts. This Administration has taken a straightforward approach to the

issues facing rural areas by directing funds to various programs that are currently expanding health care to rural areas. The Health Center program, since FY 2001, has significantly impacted over 600 communities serving 3 million more patients, over 13 million in total. Of these patients, 40 percent have no insurance coverage and many others have inadequate coverage.

The budget for FY 2006 includes $2.0 billion for these critical safety net providers, an increase of $304 million from FY 2005. As a result, services for an additional 6.1 million individuals in approximately 1,200 new and expanded sites will be available. With this increased funding, 16 million uninsured and underserved individuals will receive comprehensive preventive and primary care services at over 4,000 health center sites across the nation.

Another program that rural America will continue to benefit from is the National Health Service Corps (NHSC). Throughout its 30-year history, the NHSC has seen more than 26,000 health professionals commit to service in underserved areas across the country. A targeted management reform initiative that began in FY 2002 has allowed the NHSC to become more effective at assisting the neediest communities. The FY 2006 budget includes $127 million for NHSC. The ratio of loan repayments compared to scholarships has increased by over 30 percent, enabling the NHSC to immediately place more health professionals into service in underserved areas. The budget maintains the current field strength of more than 4,000 clinicians.

Independent evaluations indicate that these rural health programs are effective and achieve results. Information also shows that a less fragmented and more seamless Federal effort could help maximize access, generate effectiveness, yield cost efficiencies, and reduce the number of specific and geographically targeted projects funded each year.

The Administration's FY 2006 budget request for rural health care follows the lessons learned from these evaluations and research. Accordingly, the FY 2006 budget reduces $115 million in HRSA rural programs that were found to be similar to other numerous HHS programs that provide resources to rural areas.

In addition, as you mentioned, the President's FY 2006 Budget did not include funding for the Rural Hospital Flexibility Grant program, which received $40 million in the 2004 budget. The program was created in 1997. The primary purpose of the Flexibility Grants is to provide support to the States to determine if rural hospitals might benefit from conversion to critical access hospital (CAH) status. We understand that the intent was to create a program to help rural hospitals make the transition, when appropriate, to CAH status. To date, approximately 1,100 hospitals have been designated as CAHs and the States have had five years to identify those facilities that would benefit most from conversion. The majority of those conversions have taken place.

You may recall that in the early and mid 1990s, the Centers for Medicare & Medicaid Services (CMS)—then the Health Care Financing Administration (HCFA)—ran a program called the Rural Hospital Transition grants. These grants were to help rural hospitals make the transition to providing a range of services that more appropriately matched their community need and to adapt to new payment provisions such as Sole Community Hospital status, Medicare Dependent Hospital status, and the introduction of swing beds into rural hospitals. That program played a valuable role, but, by 1996, the need for these kinds of grants had waned. Similarly, the Rural Hospital Flexibility Grant program has achieved its original goals. With the enactment of the MMA and the move toward greater payment equity and flexibility for rural hospitals, there is less need for this program especially given the great pressure on

the Federal budget at this time. In addition, as mentioned above, the reduction in funds will be offset by approximately $25 billion from the rural provisions in the MMA.

Question 8:
Page 145 of the President's FY 2006 budget outlines "administrative improvements" that HHS will pursue to refine the inpatient hospital payment system, based in part on recent MedPAC recommendations. Please provide detail on which of the MedPAC-recommended payment refinements you are likely to pursue, and when?

Answer:
The first of the MedPAC payment refinement recommendations suggested that the Secretary improve payment accuracy in the hospital inpatient prospective payment system (PPS) by refining the current Diagnosis Related Groups (DRGs) to more fully capture differences in severity of illness among patients. The recommendation also suggested basing the DRG relative weights on the estimated cost of providing care rather than on charges. Finally, it called for basing the weights on the national average of hospitals' relative values in each DRG.

At this point, the Centers for Medicare & Medicaid Services (CMS) is analyzing the MedPAC recommendations. We note that the recommendations are complex and have the potential to result in significant changes to hospital payments. The FY2006 hospital inpatient PPS proposed rule, which was recently published, raises a number of issues about the specific MedPAC recommendations.

For example, regarding the severity of illness recommendation, the rule notes that CMS is planning a comprehensive review of the complication and comorbidity list for FY 2007. Another option we are considering is a selective review of the specific DRGs, such as cardiac, orthopedic, and surgical DRGs, that are alleged to be overpaid and that create incentives for physicians to form specialty hospitals. We are also considering the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR-DRGs) in place of Medicare's current DRG system.

Regarding the use of cost-based weights instead of charge-based weights, it is important to note that we do not have access to any information that would provide a direct measure of the costs of individual discharges. We use estimated costs, based on hospital-specific, department-level cost-to-charge ratios, in the hospital outpatient PPS. The accuracy of this procedure has generated some concern, and without further analysis, the extent to which accuracy of inpatient payments would be improved by adopting this method is not obvious. We will closely analyze the impact of such a change from the current charge-based DRG weights to cost-based DRG weights.

The third portion of the recommendation relates to hospital-specific relative values. In the FY2006 hospital inpatient PPS proposed rule, we note that we use this method at present to set weights for the long-term care hospital (LTCH) PPS because of the small volume of providers and the possibility that only a few providers provide care for certain DRGs. The charges of one or a few hospitals could thus materially affect the relative weights for these DRGs. This same issue does exist for hospitals paid under the hospital inpatient PPS, which are considerably more numerous than LTCHs. A 1993 Rand Report on hospital specific relative values noted the possibility of DRG compression (or the undervaluing of high-cost cases and the overvaluing of low-cost cases) if we were to shift to a hospital-specific relative value method from the current method for determining DRG weights. We will need to consider whether the resultant level of compression is appropriate.

The second major MedPAC recommendation was for the Congress to amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases. While this recommendation suggests that the law would need to be amended for us to adopt the suggestion, we believe the statute may give the Secretary broad discretion to consider all factors that change the relative use of hospital resources in calculating the DRG relative weights. We believe that MedPAC's recommendation springs from a concern that including high-charge outlier cases in the relative-weight calculation results in overvaluing DRGs that have a high prevalence of outlier cases. Rather than exclude all outlier cases from the DRG relative weight calculation, we believe it would be preferable to adjust the charges used for calculating the relative weights to exclude the portion of charges above the outlier threshold but to include the charges up to the outlier threshold. At this time, we expect to further analyze these ideas as we consider the other changes recommended by MedPAC. In the FY 2006 hospital inpatient PPS proposed rule, we welcomed public comments on this issue.

Lastly, MedPAC recommended that the Congress and the Secretary implement the case-mix measurement and outlier policies over a transitional period. Before proposing any changes to the DRGs, we would need to model the impact of any specific proposal and our authority under the statute to determine whether any changes should be implemented immediately or over a period of time.

Question 9:
The FY 2006 budget proposes a refinement of Medicare's skilled nursing facility (SNF) resource utilization groups (RUGs). As you know, after SNFs' transition to the prospective payment system in 1998, Congress enacted four temporary add-ons to the RUG rates. Two of these (a 4 percent across-the board increase for all SNF payments, and a 16.66 percent increase for nursing care) provided SNFs about $1.4 billion in annual payments, and expired on October 1, 2002. Two additional payment increases (a 20 percent increase for 15 of the 44 RUGs and a 6.7 percent increase for 14 other RUGs), provide an estimated $1 to $2 billion in annual add-on payments, and remain in effect until CMS refines the RUG system. Are you confident that CMS will refine the RUGs this year in order to realize the savings included in the President's budget ($10.1 billion over five years)? If so, what is your timeframe? How will you involve Congress and other stakeholders to institute such a change?

Answer:
The President's FY2006 budget request assumes the implementation of case-mix refinements in the coming fiscal year. The Centers for Medicare and Medicaid Services (CMS) had stated that any such proposal would be introduced through the rulemaking process and would be open for public comment. CMS issued the skilled nursing facility prospective payment system (SNF PPS) payment update for public display on May 13, 2005 (publication in the *Federal Register* occurred May 19).

This rule proposes a refinement to the resource utilization groups (RUGs) by introducing nine new payment categories. It also proposes an increase in the case mix index for all of the RUGs, equal to half the value of the temporary add-on payments that will end with the refinement of the current system. The increase in payments associated with the RUG-III refinements, together with an annual inflation increase of 3 percent, will result in virtually no change in overall SNF Medicare payments in FY 2006.

Whenever CMS issues a proposed rule, especially one that will generate the interest of the Congress and other stakeholders, we notify the interested parties to let them know about the opportunity to participate by submitting a comment on the proposed rule. The SNF PPS proposed payment update includes a 60-day public comment period. In addition, since the publication of this proposed rule, CMS has held at least one briefing, responded to numerous questions from congressional offices, and held an Open Door Forum to provide an overview of the proposed rule to the public.

Question 10:
The President's FY 2006 budget proposes an expansion of the post-acute "transfer policy," which is intended to curb inappropriate payments to hospitals that prematurely transfer patients to post-acute settings such as home health or a skilled nursing facility. The BBA of 1997 applied this provision to 10 of the highest volume diagnosis related groups (DRGs), and was accompanied by report language stating, "The Conferees expect that the application of the transfer policy to 10 high volume/high post-acute use DRGs will provide extensive data to examine hospital behavioral effects under the new transfer policy." Will you outline what HHS has learned through implementation of the 10-DRG transfer policy, and provide details as to how you plan to expand it further, including whether and when you plan to extend the policy to all inpatient DRGs?

Answer:
For the FY 2006 hospital inpatient prospective payment system (PPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) conducted an extensive analysis of the FY 2003 and FY 2004 billing data to monitor the effects of the post-acute care transfer policy when it applied to 10 and 29 Diagnosis Related Groups (DRGs), respectively. More specifically, as part of the review, CMS found that:

- Of the 550 DRGs, 26 have been deactivated and 17 have no cases in the FY 2004 MedPAR files. We are not proposing any changes for these DRGs because application of the post-acute care transfer policy to them would have no effect.

- Of the remaining 507 DRGs, 220 have geometric mean lengths of stay that are less than 3.0 days. Because the transfer payment policy provides 2 times the per diem rate for the first day of care (due to the large proportion of charges incurred on the first day of a patient's treatment), including these DRGs in the transfer policy would be relatively meaningless as they would all receive a full DRG payment. For this reason, we are not proposing any changes to the post-acute care transfer policy for these DRGs.

- Of the remaining 287 DRGs, 64 have fewer than 100 short-stay transfer cases. In addition, 39 of these 64 DRGs have fewer than 50 short-stay transfer cases. Consistent with the statutory guidance, we are not proposing any change to how we apply the post-acute care transfer payment policy to these DRGs because we believe that these DRGs do not have a high volume of discharges to post-acute care facilities or involve a disproportionate use of post-acute care services.

Once we eliminated the DRGs cited above from consideration for the post-acute care transfer policy, we examined the characteristics of the remaining 223 DRGs. We found that these DRGs had three common characteristics:

- The DRG had at least 2,000 total post-acute care transfer cases.

- At least 20 percent of all cases in the DRG were discharged to post-acute care settings.

- 10 percent of all discharges to post-acute care were prior to the geometric mean length of stay for the DRG.

Consistent with the statutory guidance giving the Secretary the authority to make a DRG subject to the post-acute care transfer policy based on a high volume of discharges to post-acute care facilities and a disproportionate use of post-acute care services, we believe these 223 DRGs have characteristics that make them appropriate for inclusion in the post-acute care transfer policy. Accordingly, we have included a proposal to do so in the FY 2006 hospital inpatient PPS proposed rule.

Question 11:
Secretary Leavitt, for years Medicare and seniors overpaid for outpatient oncology services. In response, the 2003 Medicare bill included significant changes for cancer care. In December I wrote CMS to ask what the agency was doing to ensure access to this care, and whether small and rural cancer practices were being disproportionately affected by the changes. Dr. McClellan responded in January, stating that "as of this writing, we are not aware of any problems with drug pricing." Is it still HHS' opinion that there are no problems with drug pricing? If not, what can I tell Montana oncologists, who continue to tell me the problems they are having making ends meet on Medicare cancer care?

Answer:
CMS has been actively monitoring chemotherapy claims data on an ongoing basis to ascertain whether beneficiaries' access to chemotherapy in physicians' offices has been impacted by the changes implemented during 2005. At this time, CMS does not have evidence to suggest that access problems have occurred as a result of the payment policy changes enacted by the Medicare Modernization Act of 2003 (MMA). Office-based chemotherapy care appears to be continuing at historical levels.

Question 12:
If the Administration believes that "increases in coverage among low-income individuals and families" can be achieved without "creating additional costs for the federal Government" or the states, what does the Administration mean by "coverage?" Does it mean, as under Utah's HIFA waiver, coverage for primary care services only, with no coverage for hospitalization or specialty care?

Answer:
The Administration, Congress, and Medicaid stakeholders need to discuss the Medicaid program both in terms of how it is designed to deliver health insurance coverage and long-term care services, and how it is financed. Service delivery for individuals who rely on Medicaid can be improved, and the program can be expanded to provide a basic package of health services for more of our low-income citizens. More importantly, reform should be designed to give states the tools they need to bring Medicaid into the 21st century. Medicaid's mission has changed and expanded, but its 1960s rules limit its ability to offer choices that people want and need.

We can improve coverage of optional populations. Whether it's a lady in a nursing home or a boy in a wheelchair, we have a very special obligation to our neighbors who are elderly, low-income, or have disabilities. We meet that obligation by providing a comprehensive package of benefits and services. Mandatory populations need the help. They must receive the help. The optional populations, on the other hand, may not need such a comprehensive solution. Many of them are healthy people who just need help paying for health insurance. We've already proven a way to provide that help. The State Children's Health Insurance Program (SCHIP) has allowed 6.1 million children in low-income families who don't qualify for Medicaid to have health insurance. One of the key reasons SCHIP has been such a resounding success is that it allows states to ask the question, "What is quality basic health coverage?" And each state can choose from five answers: the health benefits state employees get, the benefits federal employees get, the best private health plan in their state, Medicaid, or some hybrid of private and

government plans. Fewer than 20 states and territories chose the straight Medicaid option. A majority chose some other combination. It costs states less, on average, to provide health insurance than to provide comprehensive care. SCHIP is a proven model on which to base a discussion of how to best structure coverage for optional populations.

With regard to the Utah waiver, the waiver expansion program provided care to individuals who would not otherwise have had access. The design of the waiver focused on preventive and basic care for the expansion population. Nonetheless, progress has also been made to expand access to specialists as well. The Utah Department of Health reports that:

- Almost 600 Primary Care Network (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 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.

Question 13:
The President's budget claims new spending on health care of $142 billion over 10 years, $60 billion of which would be paid for by cuts to the Medicaid program. Does the Administration intend to pay for the net $82 billion in new spending? If so, what is the proposed offset?

Answer:
The President submitted a unified budget plan to Congress that has a variety of spending cuts and program enhancements. The budget does not identify which reductions are offsets for which spending, because it is a unified plan. The President's plan included in the FY 2006 Budget cuts the deficit in half from FY 2004 to FY 2009.

Question 14:
The President's budget is silent on the cost of easing the transition of 6.4 million dual eligibles into the new Part D program by January 1, 2006. What is the estimated cost of ensuring a smooth transition? When can we expect to see the sub-regulatory guidance that CMS will publish that will outline transition rules for this population?

Answer:
We recognize the importance of transition guidance for all Medicare beneficiaries, as well as their families, providers and advocates. Our commitment to a smooth and rational transition process begins with the process of transitioning the drug card program to Part D through structured workgroups and a Steering Committee as well as through education and outreach efforts with CMS partners and beneficiaries. Similarly, a substantial investment of CMS' research, demonstration and evaluation

resources has been requested in FY 2007 to carry out the mandates of MMA, including study of the issues in transitioning Medicare Part B covered drugs to Part D.

More specifically, at a recent conference sponsored by CMS, the National Governors Association, and the Council of State Governments, CMS discussed sub-regulatory guidance outlining the process for ensuring a smooth transition from Medicaid to Medicare prescription drug coverage for dual eligible beneficiaries. "A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage" is available on the CMS website at:

http://new.cms.hhs.gov/States/Downloads/strategyfortransitioningDE.pdf This document outlines CMS' commitment to accomplishing the safe and appropriate transition of full-benefit dual eligibles to the Medicare prescription drug program. The objectives of this commitment are: Providing Comprehensive Coverage; Ensuring Continuity of Coverage; Working with States; Establishing Appropriate Safeguards; Protecting Special Populations; and Reaching People with Medicare: Outreach and Education.

CMS has also issued formulary guidance that outlines how CMS will review Medicare prescription drug benefit plans to assure that beneficiaries receive clinically appropriate medications at the lowest possible cost. "Medicare Modernization Act Final Guidelines—Formularies" is available on our website at the following address:
http://new.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf

In addition, on May 25, 2005, CMS issued Guidance to States on the Low-Income Subsidy which details specific information about the low-income subsidy (LIS), including the application process, coordinating LIS and Medicare Savings Program applications, determining subsidy eligibility, frequently asked questions, and calculation tables. This information is available at:
http://new.cms.hhs.gov/States/Downloads/GuidancetoStatesonLimited-IncomeSubsidy.pdf

CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006. This is critically important, especially for beneficiaries who take a number of prescriptions to manage their one or more chronic conditions.

Question 15:
Please provide additional detail on the specific changes to federal law that are being proposed with respect to asset transfers.

Answer:
Current law requires individuals applying for Medicaid long-term care services to divest all but a minimum level of assets before becoming eligible. If applicants transfer assets at below market value to avoid these requirements, Medicaid rules hold them subject to delays in eligibility. Despite these sanctions, creative estate planning often allows individuals to garner Medicaid eligibility status without divesting their assets. The President's FY 2006 budget proposes to curtail this practice by tightening existing rules regarding transfers of assets.

Question 16:
The President's FY 2006 budget proposes to amend the Medicaid drug rebate formula. Specifically, the Administration proposes to eliminate the "best price" component of the formula, leaving states with a fixed rebate amount. What is the likely impact of this policy on drug prices for 340B facilities? On

large purchasers in the private market? On smaller purchasers? Please explain how this policy will be budget neutral to state Medicaid programs.

Answer:
The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called lowest private market price or best price. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. The Administration proposes replacing best price with a budget neutral flat rebate. Eliminating best price and revising the rebate percentage to offset the cost would allow private purchasers to negotiate lower drug prices. This proposal will have no effect on the Medicaid budget.

This proposal will be budget neutral to State Medicaid agencies because the flat percentage of the average manufacturers' price (AMP) rebate amount would be raised. The current 15.1 percent of AMP would be increased to the level where states would receive the same total amount in rebates across all manufacturers that they do now with the AMP and best price rebate formula.

We would not expect this proposal to have any significant effect on the 340B program since the formula for those rebates are based on the Medicaid rebate formula. As for the Medicaid program, while individual rebate amounts may vary, the overall rebate amounts should remain the same.

We have not calculated an effect on large and small purchasers in the private market, but because they could negotiate prices with manufacturers with no potential impact on best price, it is possible some of these purchases could be at a lower price.

Question 17:
The Administration is proposing to save $4 billion over 10 years by "clarifying" allowable services that can be billed for Targeted Case Management (TCM) and limiting federal reimbursement for such services to the administrative services level of 50 percent. What changes is the Administration considering to its policies? Given that a significant percentage of these services involve social services and psychological counseling and some fulfill the mandatory EPSDT requirements for children, why would you think it appropriate to only reimburse states at the administrative level?

Answer:
Case management activities are a critical part of carrying out foster care, the Individual with Disabilities Education Act (IDEA) and criminal justice programs. There is evidence to indicate that states have attempted to shift costs associated with other social service programs to Medicaid. There are instances where the Medicaid program is being charged improperly for case management services when another program should maintain responsibility for payment.

Under the proposal, the match rate for case management will be the same as it is for an administrative activity. It does not eliminate federal financial participation (FFP) for case management services, nor does it affect Medicaid eligibility for those services or any other Medicaid services. In addition, the proposal does not affect the amount of reimbursement that states will receive for Medicaid services to which an individual may be referred by a case manager.

Question 18:

In addition to the data request submitted on February 10, which addresses the Administration's IGT proposal, please describe in greater detail the proposals the President is pursuing to save $15.2 billion over 10 years through oversight of intergovernmental transfers.

Answer:
The Administration proposes to further improve the integrity of the Medicaid matching rate funding mechanism by curbing the use of financing arrangements that states use to avoid the legally determined state match requirement. Through various mechanisms, government providers return Federal Medicaid funds back to the states. States, in turn, recycle these funds by using them to draw down additional Federal dollars. The President's Budget proposes to build on current CMS efforts to curb these questionable financing practices by matching only those funds kept by providers as payment for services.

In addition, current law allows states to make Medicaid payments to providers far in excess of the actual costs of services. States use this additional money to leverage Federal reimbursements in excess of their Medicaid matching rate or for other purposes. To avoid this misuse of funds, the President's budget proposes to limit reimbursement levels for Medicaid services to no more than the cost of providing services.

Question 19:
Please describe in greater detail the proposed changes to managed care provider tax requirements assumed in the budget.

Answer:
The President's FY 2006 Budget proposes that managed care organizations (MCOs) meet the same provider tax requirements as other classes of health care providers.

Question 20:
Eighteen states are already projected to run short of federal S-CHIP funds required to serve children at current levels by fiscal year 2007. Although the Administration is proposing to reauthorize SCHIP, you appear to do so without any increase in SCHIP funding. Isn't additional funding necessary to maintain coverage in the program? How would your proposal address current shortfalls? The only change to SCHIP rules that CMS staff have identified would be to change the amount of time states have to spend their federal allocations. Are other policy changes to current S-CHIP program rules being considered? Would the Administration support requiring states to use simplified enrollment procedures to ensure greater access for eligible children?

Answer:
There are sufficient funds in the SCHIP program to meet current state needs, as well as to cover additional children that would be enrolled as a result of the comprehensive outreach efforts that President Bush has proposed through the Cover the Kids campaign. (ASBTF). States have submitted SCHIP estimates to us for FY 2005 that indicate that they only anticipate spending $5.3 billion of their available allotments. Once I have completed the redistribution of FY 2002 funds to meet the needs of the states that may otherwise have experienced shortfalls in FY 2005, there will be more than enough money to meet the needs of all states for their current enrollees, as well as to cover new children who we want to find through outreach efforts.

In addition, the Administration proposes to reauthorize SCHIP early for ten years at the current law levels and $5 billion per year in the out years. This proposal also seeks to better target SCHIP funds in a more timely manner by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Allowing the possible shortfall states to access available funds in the program sooner will keep states from having to cut back services. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year.

SCHIP represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children less than 19 years of age. SCHIP covers over 6 million children and over a half million parents and caretakers of Medicaid and SCHIP children and other adults. Enrollment in SCHIP has increased over six fold since the first year of enrollment in 1998. SCHIP is also contributing to the reduction in the number of uninsured children. The CDC reported that the percent of uninsured children has declined from 13.9% in 1997 to 8.8% in the first half of 2004, a decline attributable to the implementation of SCHIP.

The flexibility provided under SCHIP has allowed states to make innovative program design choices in application, eligibility determination, and renewing eligibility in SCHIP. Many states have joint Medicaid and SCHIP applications and allow applicants to apply by phone and online. Renewing eligibility in SCHIP has also been simplified. Many states only require enrollees to renew eligibility every 12 months and have simplified renewal applications by asking enrollees to update their information as opposed to re-applying to the program. Presumptive eligibility allows states to enroll children at the point of service if a child appears to be eligible for SCHIP, which in turn allows children to receive care more quickly. Nine states have adopted the presumptive eligibility in SCHIP.

Although SCHIP has experienced tremendous enrollment success and given a great deal of flexibility to states, there are still many children who are eligible for SCHIP and Medicaid yet not enrolled. The Administration is proposing the $1 billion Cover the Kids campaign in order to continue the progress made by SCHIP in covering uninsured children. The Cover the Kids campaign will provide grants to states, community- and faith-based organizations, schools, and other organizations that have the experience, knowledge, and commitment to enrolling eligible children in Medicaid and SCHIP.

Question 21:
I realize that the issue of SCHIP outreach was addressed in the hearing. However, I have a few follow-up questions regarding the Administration's proposal for a "national outreach campaign" of $1 billion in grants over two years "to enroll as many Medicaid- and SCHIP-eligible children as possible." Will these grant funds be available for states to distribute, or will they also be available directly to community-based groups without state oversight?

Answer:
A national outreach campaign would be established. It would provide $1 billion over two years in outreach grants to states, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. The new initiative will use a portion of these funds for new outreach programs at the community level to rekindle efforts to find and enroll these uninsured children. These funds would go directly to schools, community organizations, and tribes. The initiative will also include funding for a Federal outreach campaign. Finally, the initiative will reward states that are most successful in increasing enrollment by providing funding in the form of

performance-based grants to states that increase health insurance coverage to children in families with income less than 200 percent of the federal poverty level.

- On what basis will the grant funds be allocated among the states? Will there be any conditional requirements states would have to meet to receive a grant? If so, what requirements are being considered?
- Are you proposing that the grant funds be discretionary or mandatory spending?
- Will the states be required to match the federal grant funds with their own funds? If so, at what rate?
- How many states do you expect will apply for grant funds?
- How "national" do you expect this outreach initiative to be? Specifically:
    - Do you expect states like Tennessee, which is planning to disenroll 323,000 adult beneficiaries, or Mississippi, which is planning to disenroll 50,000 elderly and disabled beneficiaries, to apply?
    - Do you expect the 29 states with declining federal matching rates in FY 2006 (starting this October 1) to apply for grants and enroll more children?
    - Do you expect the 12 states that have shortfalls in S-CHIP funding in FY 2006 and the 18 states that have shortfalls in S-CHIP funding in FY 2007 to apply for grants and enroll more children?
    - You propose a total of $23 billion over 10 years in savings from four different restrictions on the use of IGTs and provider taxes. These proposals, if enacted, will require the affected states to find different sources of funds if they wish to maintain their current level of Medicaid spending. Do you expect that these affected states will apply for grants to enroll more children in their programs?

Answer:
The proposal is included in the State Grants and Demonstration account as mandatory spending.

- **How many children do you expect to enroll as a result of this national outreach initiative in each year of the 5-year period?**

Answer:
Estimates made by various organizations put the number of uninsured children at 9 million. It is expected that three quarters of those could be eligible for Medicaid or SCHIP. The innovative approaches included in the President's FY 2006 budget will work to reduce that number.

- **Your estimate for the total 10-year cost of this initiative is $11.3 billion, yet only $1 billion is grant funding. Of the remaining $10.3 billion, how much do you estimate is attributable to new Medicaid spending, and how much is attributable to new S-CHIP spending?**

Answer:
The President's FY 2006 Budget estimates that Medicaid costs would be $ 10.05 billion between FY 2006 and FY 2015 while SCHIP costs would be $267 million over the same period.

- **How much additional state-only dollars do you estimate states will spend to match your estimated $10.3 billion in federal spending? Where will these state-only dollars come from, given that you project program spending will increase about 7 percent per year without any additional enrollment?**

Answer:
We would estimate that the total state spending to match the $10.3 billion in new spending would be about $7.6 billion. While we understand the states' share represents new spending to cover previously uninsured children, given the improving fiscal condition of states and the long term benefits of investing in the health care and coverage of our children, we believe states will have the incentive to fund provide the necessary funds.

- **Page 138 of the President's FY 2006 budget indicates that, although the S-CHIP program does not expire until the end of FY 2007, the Administration this year "will seek authority to better target S-CHIP funds in a more timely manner." The Budget does not appear to provide any new federal funds for this authority. How will this new S-CHIP authority accommodate the Administration's predicted increase in enrollment resulting from the national outreach initiative?**

Answer:
The Administration proposes to reauthorize SCHIP early for ten years at the current law levels and $5 billion per year in the out years. In addition, this proposal seeks to better target SCHIP funds in a more timely manner. The proposal accomplishes this by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year. With this change we believe there will be sufficient funds to accommodate the additional enrollment in SCHIP resulting from the Cover the Kids initiative.

Question 22:
Page 139 of the President's budget describes LTC Partnership Programs as "a proven approach to lowering Medicaid costs."

- What has been the Medicaid cost experience with the LTC Partnership Program? Has the Program cost Medicaid or saved Medicaid money in each of the states?

- What has been the cost experience of consumers participating in the LTC Partnership Program? Have program participants saved money as a result of their participation in the Partnership Program?

- Has the LTC Partnership Program reduced the incentive for individuals to pursue asset transfers ahead of the Medicaid "look-back" period in order to be eligible for Medicaid?

Answer:

- Each of the four states has done their own analysis of the cost impact of the Partnership and each state came to the conclusion that the program saves Medicaid money. The following example is taken from the Connecticut Partnership's annual report to the legislature:

  "As noted above, the Partnership is also generating Medicaid savings in the short-term. Through purchaser survey data and claims information to date, it is estimated that as a result of the Connecticut Partnership, the State's Medicaid program has saved approximately $1.8 million (half of these savings would accrue to the federal government). This estimate is based on the assumption that a certain number of purchasers of Partnership insurance policies would have transferred assets and accessed the Medicaid program in the absence of the Partnership program."

- As of June 2005 less than 200 persons had used Partnership insurance benefits and also used Medicaid long-term care benefits. We know of no survey of participants using both the private and public aspects of the program. However, anecdotal evidence from the insurance industry suggests that lapse rates for Partnership policyholders are lower than for those in the traditional market suggesting at least a comparable level of satisfaction.

- The Connecticut Partnership surveys participants about their reason for participation. Approximately one third of the purchasers stated that they purchased a Partnership policy as an alternative to transferring assets to qualify for Medicaid.

Question 23:
The President's budget claims new spending on health care of $142 billion over 10 years, $60 billion of which would be paid for by cuts to the Medicaid program. Does the Administration intend to pay for the net $82 billion in new spending? If so, what is the proposed offset?

Answer:
The President's Budget is a unified budget that includes a number of initiatives and spending reductions that in total cut the deficit in half by 2009. The President's Budget does not designate which reductions should pay for which things, but rather sets out a unified package of policies that the Administration supports. We support Congress adopting all of the President's Budget proposals. For more information about the President's proposals for savings and reforms, please refer to the volume of the budget titled, "Major Savings and Reforms in the President's 2006 Budget." You can access this volume on line at:

http://www.whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf.

Question 24:
I have mentioned Libby, Montana several times at the past two hearings and in my questions. Since news reports first brought the tragedy in Libby to light in 1999, I have helped secure federal dollars for cleanup, health care, and economic development, and I have personally visited Libby more than 15 times. This is clearly a priority for me. But there is much more that needs to be done. In addition to asbestos clean up and economic development clean up, affordable health care is one of the biggest hurdles the town is facing. Additional federal dollars will be needed for continued funding of the CARD clinic, which has done a tremendous job providing health care and screening for Libby residents. I am also working to establish a new research center in both Missoula and Libby to help develop long-term solutions for treating people with asbestosis and related diseases.

I would very much appreciate if you will consider visiting Libby, Montana with me at some point. I recognize that you made this trip as EPA Administrator, but I would greatly appreciate a follow-up visit in your new capacity. In addition, my senior health staff will be traveling to Libby over the next Congressional recess, and I would like to request that one of your staff make a trip to Libby at that time in order to gain a better understanding of the needs of the residents there.

Answer:
Thank you for the invitation, Senator Baucus. I look forward to visiting Libby in my capacity as HHS Secretary. As you are aware, HHS has been very much involved in helping the citizens of Libby. And since my appearance before the Senate Committee on Finance, on February 16, 2005, the Agency for Toxic Substances and Disease Registry (ATSDR), an environmental public health agency within the Department, has made several trips to Libby, Montana.

Sharon Campolucci, RN, MSN, and Vik Kapil, OD, MPH, met in Libby on March 16, 2005, with the Montana Department of Public Health and Human Services staff concerning ATSDR's Montana Asbestos Screening and Surveillance Activity (MASSA) program. They also met with the MASSA program staff. In addition, while in Libby they met with two physicians from the Center for Asbestos Related Disease (CARD) in Libby (Drs. Alan Whitehouse and Brad Black) and a community member (Gayla Benefield) to discuss the MASSA program. They also met with Lincoln County Commissioner Rita Windom.

Ted Larson, MS, an ATSDR epidemiologist, met in Libby on October 17, 2005, with radiologists working on ATSDR's Former Worker Radiographic Progression study.

Dan Strausbaugh, ATSDR Regional Representative who maintains an ATSDR Montana Office in Helena, travels routinely, approximately monthly, to Libby and made the trip several times since February. He regularly attends the Asbestosis Related Disease (ARDnet) meeting. This group was established through a HRSA grant to Lincoln County. ARDnet has also received funding from the Montana State Legislature. He also provides support services to the Montana Department of Public Health and Human Services, which continues to provide medical screening in Libby through an ATSDR grant. Strasbaugh, a member of the U.S. Public Health Service Commissioned Corps, frequently accompanies state officials, such as the governor, the state medical officer, or the contract physician, to Libby. He also assists the state with media and community communication. He has met with hospital administrators in Libby, county commissioners, and others in support of the state and their efforts to provide quality medical screening to qualified people.

Please rest assured that HHS remains committed to the work we've begun to address the needs and concerns of Libby's residents.

Question 25:
The FY 2006 budget eliminates funding for the Health Careers Opportunity Program (HCOP), which is intended to increase the number of persons from disadvantaged backgrounds in the health and allied health fields. The University of Montana uses HCOP funding to help disadvantaged and American Indian students pursue careers in pharmacy, physical therapy or other allied health fields. The University of Montana currently has 10 Native Americans in its School of Pharmacy who participated in the HCOP program. Three of these students are from Browning, Montana. At the time of the 2000 census, the per capita income in Browning was $8,955, compared with $21,587 nationally. Given the

University of Montana's success in training Native American students to practice pharmacy, don't you think this important initiative should be allowed to continue?

Answer:
The HCOP program has initiated a process for recruiting, retaining, and graduating disadvantaged students. Other sources of funding through partnership linkages with private and corporate entities are available now to provide support for health professions training. Private foundations have put resources into increasing the number of disadvantaged and minority students entering the health professions and other science-disciplines, thus reducing the dependency on the Federal Government to fund these activities.

In particular, more than 400 partnerships have been formed, building a health career education pipeline by extending activities to the K-12 educational level, community-based entities, secondary schools, undergraduate schools, schools of allied health and health professions schools. The University of Montana College of Pharmacy and Allied Health has established a solid foundation in grantsmanship aimed at increasing the number of disadvantaged students entering health professions education.

Question 26:
The President's FY 2006 Budget included an increase in the budget authority for the Indian Health Service of $63 million. This number represents the balance of a $145 million increase in spending on health services, a $73 million reduction in spending on facilities and construction, and $9 million in additional funding from health insurance collections.

The administration says these numbers keep pace with inflation and population growth. However, I have a number of concerns with this picture. First, the budget cuts health facilities spending at the expense of increasing services – funding for both is essential, as the delivery of quality health care services requires the kind of safe, modern, and adequately-sized facilities that are lacking in Indian Country. Second, while this increase may keep pace with inflation to maintain existing funding levels for services, we know that the current funding level is inadequate to meet the health care needs of the Indian population. What plans do you have to fulfill the need for construction and repairs for the health care facilities at which IHS services are delivered?

Answer:
IHS's FY 2006 budget request includes a one year pause in the initiation of new construction, allowing additional available funding to be concentrated on the provision of health services. Consistent throughout the Department of Health and Human Services, FY 2006 requests for facilities funding focus on maintenance of existing facilities; no funding is requested to initiate new projects. Since FY 2001, a total of $321 million has been provided to complete 14 IHS facilities. For health facility maintenance and improvement, the IHS budget request includes a total of $129 million, an increase of $6.2 million over FY 2005. IHS is also working with Tribes to revise the current health care facilities priority system to better address the needs for health care facilities.

Question 27:
What plans do you have to work with Congress and the Indian Tribes to pass legislation that will reauthorize the Indian Health Service and better enable the agency to do its job to meet the health care needs of this population? What resources and staff time will you commit to this work, and how soon?

Answer:
I know that the Indian Health Service has an important mission and responsibility in working with Tribes, Tribal organizations and Urban Indian health organizations toward achieving its mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

S.1057, the "Indian Health Care Improvement Act Amendments of 2005" was introduced on May 17 and I look forward to working with the Committee to continue to improve the availability and quality of health care for American Indian and Alaska Native people.

Question 28:
In a previous question for the record submitted in conjunction with your nomination hearing, I asked about the health care facility on the Fort Peck reservation in Montana. It is badly 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:
IHS has developed the Health Facility Construction Priority System (HFCPS) to determine where new or replacement health facilities are needed most. This methodology compares the relative need for new health facilities throughout IHS examining factors such as: projected local demand for health services, capacity and condition of any existing health facility, and distance to nearest alternate health facilities (including non-IHS health facilities). The development of HFCPS has been an effective strategy for reaching agreement between the Administration, Congress and the Tribes about which facilities to replace first.

As you know, the Verne E. Gibbs Health Center at Fort Peck is not on the current HFCPS. The Indian Health Service is in the process of developing a new priority methodology for the replacement of health facilities. A new list, based on the new priority methodology, will be developed and implemented when all projects on the current list have been funded.

A 10-year master plan for facilities in the Billings Area has been developed which includes the Verne E. Gibbs Health Center. Within the Billings Area the Verne E. Gibbs Health Center is one of the facilities in most critical need of replacement. The results of the Billings and other Area master plans will be used to rank order facilities for the new priority list.

The Indian Health Service continues to provide Maintenance and Improvement funding to maintain and improve the facility. Currently the Indian Health Service has contracts with the Fort Peck Tribes in the amount of $797,133 to make necessary repairs and improvements.

Question 29:
The president's budget proposes increasing funding for abstinence-only programs by $38 million, to $206 million this fiscal year. A recent report by the House Committee on Government Reform revealed that many of the most common federally funded abstinence-only curricula contain errors, distortions and stereotypes such as that "the popular claim that 'condoms help prevent the spread of STDs,' is not supported by the data;" and exposure to sweat and tears are risk factors for HIV transmission. Do you

believe it is appropriate to fund curricula that deliberately provide false or misleading information? Are there any other cases in which U.S. taxpayer funds are used to deny or censor medically accurate information?

Answer:
I believe it is the responsible and appropriate thing to provide youth with accurate information on the most effective way to prevent unwanted pregnancies and sexually transmitted diseases which is abstinence until marriage.

Question 30:
Do you support the Senate's investigation into the Administration's promotion of abstinence-only programs that have recently been revealed as disseminating "false and misleading information about reproductive health"?

Answer:
If the Senate believes an investigation into abstinence-only programs is warranted, the Department would be willing to assist in such an investigation.

Question 31:
As Governor of Utah, you supported a range of approaches to dealing with sex education and vetoed a state-abstinence-only-until-marriage bill that would have prohibited discussion of birth control in sex education courses in schools. However, you also took steps to emphasize that abstinence and fidelity should be the essential core of sex education instruction for students in Utah. Given this experience, would you support funding for "abstinence-plus" education as a part of welfare reform reauthorization?

Answer:
I support the President's proposal which is incorporated into the House welfare reauthorization bill, H.R. 240. This bill includes the Administration's desire to reauthorize the Section 510 Abstinence Education Program as it currently exists.

Question 32:
Leading medical and public-health organizations such as the American Medical Association, the American Academy of Pediatrics, and the American Public Health Association, among others, support sex education that includes information on BOTH abstinence and contraception? And that the public – including parents – oppose programs that censor health information about contraception? Should the recommendations of the public and these organizations be ignored?

Answer:
I believe abstinence until marriage is the most effective way to prevent unwanted pregnancies and sexually transmitted diseases. More importantly, abstinence education is what teens want. According to the National Campaign to Prevent Teenage Pregnancy, 93 percent of teens believe they should be given a strong message about abstinence. In a 2002 study by Mathematica Policy Research, they found that "Youth tend to respond especially positively to programs when the staff are unambiguously committed to abstinence until marriage and when the program incorporates the broader goal of youth development."

Question 33:
As Governor of Utah, you supported a tax credit for moderate and low-income parents who provide full-time at-home care of infants. Would you support similar efforts or demonstrations at the federal level to reimburse low-income parents for at-home care of infants?

Answer:
I would defer to the Treasury Department regarding questions on tax credits and note that the President's budget does not include funding for demonstrations at the federal level to reimburse low-income parents for at-home care of infants. Further, the Administration firmly believes that the primary reason for the success of welfare reform is the focus on moving individuals to work as quickly as possible. While we continue to support State flexibility with respect to the treatment of parents with very young children as currently provided under the Temporary Assistance for Needy Families (TANF) program, we would not support any changes that could potentially lessen the focus on work.

The Honorable Jeff Bingaman

Question 1:
During your confirmation hearing, I wrote to ask the following question: "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?"

You responded as follows: "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."

Would the Administration support modification of that statutory provision and be willing to work with the Congress on such a modification?

Answer:
The administration will work closely with Congress to implement any law that Congress chooses to enact.

Question 2:
The 6.4 million low-income seniors that are considered "dual eligibles" are potentially worse off under the prescription drug proposal, as their copayments will increase, their access to the full array of drugs will be more limited, their ability to appeal coverage decisions will be more restricted, and the number of asset tests they face may potentially increase from 1 to 3. Would the Administration be willing to work to see if we can, at the very least, ensure that we ensure that the bill does no harm to them?

Answer:
Under the new drug benefit, about 6.3 million full-benefit dual eligible low-income beneficiaries will have no premium or deductible and nominal co-pays of as little as $1 or $3 per prescription. Of the dual eligible beneficiaries, about 1.5 million who are institutionalized are totally exempt from cost sharing. They will pay no premiums, no deductibles, no coinsurance, and no co-payments. Dual eligibles will have access to a comprehensive drug benefit with no limits on the number of prescriptions as is the case in many Medicaid programs. They will be automatically qualified for the low-income subsidy program and will not face any Federal asset tests associated with the Part D subsidy program.

CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit

starts on January 1, 2006. This is critically important, especially for beneficiaries who live in long term care settings, and beneficiaries who take a number of prescriptions to manage their one or more chronic conditions.

CMS review of prescription drug plan formularies will ensure that plans offer a comprehensive array of drugs that reflects best practices in the pharmacy industry as well as current treatment standards. Our goal is to ensure beneficiaries receive clinically appropriate medications at the lowest possible cost. In reaching this goal, we also need to acknowledge the specific needs of individuals with certain medical conditions who are already stabilized on certain drug regimens (for example, enrollees with HIV/AIDS, mental illness, and those with other cognitive disorders).

To address the needs of individuals who are stabilized on certain drug regimens, Part D plans are required to establish an appropriate transition process for new enrollees who are transitioning to Part D from other prescription drug coverage, and whose current drug therapies may not be included in their Part D plan's formulary. This transition process will need to address the plan sponsor's method of educating both beneficiaries and providers to ensure a safe accommodation of an individual's medical needs with the plan's formulary. We believe some period of adjustment may be necessary to introduce the new formulary requirements, and set forth our expectations of what constitutes a reasonable transition timeframe.

CMS has also developed appeals procedures that ensure enrollees quickly receive decisions regarding medically necessary medications. For example, if an enrollee requests a coverage determination or exception, the plan must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination.

Additionally, CMS has established specific protections for beneficiaries who live in long-term care facilities and get their prescriptions from long-term care pharmacies. As a condition of providing the new benefit, every plan must provide coverage to all its enrollees who live in any nursing home in its region. To help facilitate the transition, the Medicare prescription drug plans will be notified as to which of their enrollees live in a long-term care setting. This will help the plans and the facilities prepare for any potential changes to a beneficiary's drug regimen. Because a large number of long-term care residents are full-benefit dual eligibles, it is important for the transition process that plans employ to account for any issues associated with filling the first prescription of a non-formulary drug. Medicare prescription drug plans will need to ensure that long-term care pharmacies in their network work with long-term care facilities before enrollment begins to ensure a smooth transition.

Taken in total, all of these features will ensure that all dual eligibles receive the maximum benefit from the new drug benefit.

Question 3:
The new Part D plans may fall short of those currently covered under Medicaid. As you know, a huge percentage of seniors in these chronic disease categories are dual eligibles, and now get their medications covered through Medicaid. Because states are generally prohibited from simply deciding not to cover a particular drug, I think it's fair to say that Medicaid prescription drug coverage – in any given state – is vastly more comprehensive that what's going to be available through the Part D plans since plans can narrow an entire therapeutic class to just two medications. Although beneficiaries can appeal a decision by their Part D plan, it is not clear how well these appeals procedures will work, particularly for dual eligibles with limited financial resources and may have physical or cognitive impairments.

Via regulation or legislative corrections, are you going to follow the example of over 20 states by providing a special exemption for the medications needed by people with Alzheimer's and severe mental illnesses such as schizophrenia?

Answer:
CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006. This is critically important, especially for beneficiaries who live in long term care settings, and beneficiaries who take a number of prescriptions to manage their one or more chronic conditions.

In addition, CMS review of prescription drug plan formularies will ensure that plans offer a comprehensive array of drugs that reflects best practices in the pharmacy industry as well as current treatment standards. Our goal is to ensure beneficiaries receive clinically appropriate medications at the lowest possible cost. In reaching this goal, we also need to acknowledge the specific needs of individuals with certain medical conditions who are already stabilized on certain drug regimens (for example, enrollees with HIV/AIDS, mental illness, and those with other cognitive disorders).

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In the formulary guidance, CMS articulates its expectations that best practice formularies contain a majority of drugs within the following classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics. Following

common best practices, CMS will check to see that beneficiaries who are being treated with these classes of medications have uninterrupted access to all drugs in that class via formulary inclusion, utilization management tools, or exceptions processes.

Question 4:
Section 1015 of the Medicare prescription drug bill provides CMS with $1 billion for fiscal years 2004 and 2005 to implement the bill. I firmly believe the best use of these funds would be to increase the budget for State Health Insurance Assistance Programs (SHIPs) rather than run television advertisements that fail to provide real information.

What part of the $1 billion is CMS planning to spend on SHIPs and how will the remaining funds be spent?

Answer:
In FY 2004, a total of $7.6 million of the $21.1 million in SHIP funding was from the $1 billion MMA funds and in FY 2005, a total of $16.5 million of the $31.7 million in SHIP funding was from the $1 billion in MMA funds. So, a total of $24.1 million from the $1 billion MMA funds was awarded to the SHIPs. The remaining funds will be spent on beneficiary outreach and education, information technology, administrative needs, special projects such as contracting reform, collaborative efforts with other agencies, quality of care projects including chronic care improvement, combating fraud and MMA research mandates.

Question 5:
I have called on the Administration to auto-enroll low-income dual eligibles into the drug card to get the $600 transitional assistance (TA) credit on many occasions in the past year. In April 2004, the Administration estimated 50,000 low-income New Mexico Medicare beneficiaries would be receiving the $600 credit. However, in January 2005, CMS acknowledged that just 11,000 were receiving the credit. By any measure, this is far short of what was anticipated.

What additional steps will HHS take to get more low-income New Mexico Medicare beneficiaries enrolled in the drug card so they can get the $600 credit? What steps is HHS taking to ensure that there is not a disaster forthcoming with respect to enrollment of low-income beneficiaries into the low-income drug benefit in January 2006?

Answer:
The Medicare Modernization Act prohibits full-benefit dual eligible beneficiaries from receiving benefits under the Medicare Drug Discount Card, and the subsequent $1200 in transitional assistance over the 2-years ($600 each year) of the drug card program.

CMS did, however, facilitate the enrollment of the Medicare Savings Program beneficiaries (QMB, SLMB, and QI's) into the Medicare Drug Discount Card Program. In fact, all MSP beneficiaries were automatically deemed to meet the income portion of the eligibility standard for the $600 transitional assistance, through just a simple attestation. All MSP beneficiaries were sent a notice by CMS that they may be eligible

for the $600. The MSP beneficiary needed only attest to whether the beneficiary had drug coverage from other sources such as TRICARE, FEHBP, or private insurance.

CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006.

Full-benefit dual eligible beneficiaries automatically qualify for assistance with their Medicare prescription drug plan costs and do not need to file an application for the low-income subsidy. Certain other groups are also automatically eligible for this assistance including Medicare beneficiaries who are recipients of Supplemental Security Income (SSI) and participants in Medicare Savings Programs as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). Other beneficiaries with low incomes and limited assets (including savings and stocks but not counting one's home) who do not fall into one of the automatic subsidy eligibility groups will need to apply for this extra help. In May 2005, CMS will begin mailing notices to dual eligibles informing them that Medicare will begin providing prescription drug coverage through Medicare prescription drug plans and that they qualify for extra help paying their Medicare prescription drug plan premium, deductible and cost-sharing. The notice will also explain that additional information will be available in October 2005 about the specific Medicare prescription drug plans in their area.

Additionally, the Social Security Administration (SSA) will be mailing a letter and an application to almost 19 million people who are potentially eligible for extra help beginning in late May and the mailings will continue through August. We encourage everyone who receives this letter and application to fill out this application so they can get the extra help from Medicare to pay for their prescription drug coverage.

Question 6:
In the Medicare prescription drug bill, there was $250 million for each of four years to reimburse health providers for emergency services provided to undocumented immigrants.

In 1986, Congress enacted the State Legalization Impact Assistance Grant (SLIAG) program to help state and local governments with the costs associated with converting to legal status under the amnesty program. Unfortunately, the regulations were so difficult that states such as New Mexico were unable to fully draw down funding intended to help health providers in border communities.

CMS has recently issued some draft guidance on the matter that many feel will be overly onerous on health providers to receive reimbursement. The paperwork requirements for providers needs to be as simple as possible without overly restrictive definitions and billing procedures.

The Administration has missed its own deadline on implementation of this provision. When does HHS plan on implementing this provision of MMA?

Answer:
Undocumented immigrants' use of medical services has been a long-standing issue for hospitals, particularly among those located along the U.S.-Mexican border. As required by federal law (the Emergency Medical Treatment and Labor Act, or EMTALA), hospitals participating in Medicare must medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those who have an emergency condition, regardless of payment method or insurance status.

As you know, in an effort to assist hospitals and other providers with their uncompensated care costs, Congress included a provision in the Medicare Modernization Act (MMA)—Section 1011—to set aside $1 billion through 2008 to help hospitals and other emergency providers recoup some of the expenses of providing this critical care.

On May 9, 2005, the Centers for Medicare & Medicaid Services (CMS) issued its final guidance regarding the implementation of Section 1011. This guidance was published in the Federal Register on May 13, 2005. Providers can claim payment for emergency services furnished to eligible patients beginning May 10, 2005. The Federal Register notice and related information collection instruments can be found at http://www.cms.hhs.gov/providers/section1011.

In this final implementation plan, we worked closely with the hospital industry as well as patient advocacy organizations to revise our implementation approach. We believe the final implementation plan will target funds to those providing substantial uncompensated care to undocumented immigrants, while also avoiding any substantial new burdens on these health care providers.

Question 7:
Studies indicate that payments to Medicare HMOs are 7 to 15 percent higher, on average, compared to traditional Medicare. These payments in excess of Medicare fee-for-service result in higher premiums for all Medicare beneficiaries, including those that do not enroll or do not even have access to a Medicare Advantage plan.

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

Answer:
Congress made deliberate decisions in the way Medicare Advantage payments are determined. Section 211(a)(1)(i) of the Medicare Modernization Act (MMA) required CMS to exclude payments for direct graduate medical education but did not exclude

indirect graduate medical education payments as part of the calculation in determining Medicare Advantage payments. This intent has been to maximize plan choices for beneficiaries across the country, especially in rural parts of the country where plans had previously not been offered. In addition, these plans will be able to offer better benefits and more coordinated care than traditional Medicare at a lower cost to beneficiaries.

Question 8:
The Public Health Service 340B Program offers important financial assistance to providers making up our nation's healthcare safety net.

What level of priority is your office giving to matters relating to the 340B program, such as the widespread allegations of manufacturer overcharges and inadequate governmental oversight of the program? What resources do you plan to commit to further scrutiny of 340B program operations, administration and pricing practices in the coming year?

Answer:
The 340B Drug Pricing Program was established in response to the passage of Section 340B of U.S. Public Law 102-585, the Veterans Health Care Act of 1992. Section 340B of this law limits the cost of drugs to federal purchasers and to certain grantees of federal agencies. Significant savings on pharmaceuticals may be seen by those entities who participate in this program." The program is administered by the Office of Pharmacy Affairs (OPA) of HRSA, under the federal Department of Health and Human Services (HHS)

HRSA places high priority on the management of the 340Bprogram, within resources it has to allocate to it. Allegations of manufacturers charging prices in excess of those permitted under the Section 340B of the Public Health Service Act have been made by both the OIG and the DOJ. The DOJ actions have resulted in cooperate integrity agreements and refunds of excess prices to the affected 340B clinics or hospitals. Our understanding is that the OIG is conducting a new study of manufacturer pricing practices under 340B. The results of which should assist HRSA to better assess additional actions that it should take and the resource requirements for those actions.

In follow up to OIG criticizism of the integrity of HRSA's web database of participating covered entities authorized to purchase 340B discounted drugs., HRSA contracted with an outside organization to define the requirements of a system that would remedy identified problems. HRSA then began to fund the multiyear development of this system. HRSA has sought input from participating safety-net providers, manufacturers, wholesalers and other stakeholders on the systems requirements. And on August 15, of this year a major portion of this new web accessible database became operational. The entire database is expected to be complete by the end of 2006.

HRSA began in October 2005 to assume responsibility for the calculation of the Government's 340B Ceiling Prices for each manufacturers' drugs. HRSA will use CMS provided data on Average Manufacturer Prices and Medicaid Unit Rebate Amounts in its calculations. Package size data will be purchased from a third party vendor and used by

HRSA in the formula for the 340B calculations. HRSA proposes to compare its calculated prices with those of drug manufactures and those of the drug wholesalers beginning in 2006. HRSA will continue to monitor the program and its resource needs.

Question 9:
In March 2003, the OIG reported investigatory findings that five manufacturers had collectively overcharged 340B entities for 11 different drugs during fiscal 1999, yet only recently was any action taken to follow up on these findings with the involved manufacturers.

Why has it taken so long for there to be any follow up activity, and what, if any, action can be expected from the OIG if manufacturers identified as having overcharged 340B providers fail to reimburse the identified overcharges?

Answer:
In a March 2003 audit, the OIG found that five pharmaceutical manufacturers overcharged 340B-covered entities $6.1 million for sales during the one-year period ending September 30, 1999. The OIG recommended that HRSA as administering agency seek refunds for the affected safety-net provider. In September 2004, HRSA sent letters to these companies requesting corrected action plans for repayment of the OIG stated overcharges. HRSA continues to work with CMS, OIG and the drug companies to resolve issues related to ascertaining the actual overcharges and recovery of such funds. The Department of Justice is investigating one of the companies and thus HRSA has temporarily suspended interactions related to this issue with the one company.

The statute provides for termination of the manufacturer from both the Medicaid and the 340B program if there is non-compliance with the program requirements. In lieu of utilizing such a drastic enforcement tool, HRSA and CMS, together, have always tried where problems have been and are identified to work with the companies to resolve those problems.

Question 10:
The Administration's budget proposes no overt Medicare cuts, but there is one very significant and potentially devastating Medicare cut in the president's budget plan that I cannot overlook. Some have estimated that the line in the budget on skilled nursing facility payments related to RUGs will cut $24 billion over the next ten years from Medicare for beneficiaries needing care in nursing homes. These are the sickest seniors and this sector of health care is by far the most fragile economically. We saw huge numbers of bankruptcies when similar cuts were made in 1997.

What makes you think we'll not see similar devastating results from cuts of the magnitude you propose?

Answer:
We realize that the elimination of the $1.4 billion temporary add-on to the skilled nursing facility (SNF) prospective payment system (PPS) raises concerns about how the change

will impact the quality of care in our nursing homes. First, I want to assure you that quality improvements in nursing home care have been a priority for this Administration and we plan to continue our efforts in this direction.

Second, while it is true that a number of nursing homes filed for bankruptcy shortly after the introduction of the SNF PPS, the financial problems these companies experienced were not necessarily related to the SNF PPS. In fact, a Government Accountability Office review ("Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but Maintain Access," GAO/HEHS-00-23, December 1999) of two of the largest publicly held chains (Vencor and Sun Healthcare Group) found that the financial position of both firms suffered from high capital-related costs; substantial, non-recurring expenses and write-offs; and reduced demand for ancillary services related to several other provisions in the Balanced Budget Act of 1997. Vencor's SNF operations remained profitable after the implementation of the SNF PPS. In addition, there were a number of media reports that cited rapid expansion into other lines of business, high capital costs, and inadequate cost controls as other factors influencing the financial status of the SNF industry.

The Department of Health and Human Services' Office of Inspector General (OIG) conducted two studies on beneficiary access under the SNF PPS ("Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities," OEI-02-99-00400, August 1999; and, "Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective," OEI-02-99-00401, October 1999). These studies, which surveyed nursing home administrators and hospital discharge planners, found no widespread access problems in placing Medicare beneficiaries in SNFs. The OIG confirmed these preliminary findings in a follow-up study, "Medicare Beneficiary Access to Skilled Nursing Facilities: 2000," OEI-02-00-00330, September 2000, which indicated that almost all discharge planners reported being able to place Medicare beneficiaries in SNFs. Further, Medicare data show a decrease in the average length of hospital stays for beneficiaries prior to a SNF admission, suggesting that the hospital stays are not being prolonged by a delay in SNF placement.

While Congress enacted four add-on payments to the SNF PPS rates, the intent was to establish the adjustments as temporary measures only. In fact, two of the temporary add-on adjustments expired, according to statute, in 2002. At that time, there were also concerns about the negative impact the payment reduction would have on quality. These concerns were not realized, as evidenced by the positive profit margins reported for the SNF industry. In its March 2005 report, the Medicare Payment Advisory Commission estimated that the estimated aggregate 2005 Medicare margin for freestanding SNFs (the majority of SNF providers) is 13 percent.

The remaining add-on payments are scheduled to expire when the Centers for Medicare & Medicaid Services (CMS) implements refinements to the case-mix classification system. The President's FY2006 budget request assumes the implementation of case-mix refinements in the coming fiscal year. CMS had stated that any such proposal would be

introduced through the rulemaking process and would be open for public comment. CMS issued the SNF PPS payment update for public display on May 13, 2005 (publication in the *Federal Register* occurred on May 19).

This rule proposes a refinement to the resource utilization groups (RUGs) by introducing nine new payment categories. It also proposes an increase in the case mix index for all of the RUGs, equal to half the value of the temporary add-on payments that will end with the refinement of the current system. The increase in payments associated with the RUG-III refinements, together with an annual inflation increase of 3 percent, will result in virtually no change in overall SNF Medicare payments in FY 2006.

The SNF PPS proposed payment update includes a 60-day public comment period.

Question 11:
Secretary Leavitt, in a speech you gave on February 1st entitled "Medicaid: A Time To Act," you laid out some of the rationale for the $60 billion in cuts the Administration has laid out for the Medicaid program.

In that speech, you spoke about what you called the "Seven Harmful Habits of Highly Desperate States" and said that the federal government needed to crack down on attempts by states to shift or maximize federal Medicaid costs through mechanisms like intergovernmental transfers and certain provider taxes. You specifically said, "It's time for me to have an awkward conversation with Mr. States. I want to restore a straightforward, transparent, and effective system."

I would agree that we should limit such practices and have a dialogue with all stakeholders in the Medicaid program present and in the room discussing the future of Medicaid. It is for that reason that I was pleased to be the lead cosponsor of legislation with Senator Smith to create a "Bipartisan Commission on Medicaid." I would note this legislation now has 20 sponsors – 10 Republicans, 9 Democrats, and 1 Independent.

However, I would underscore that the key word here is "dialogue." A $60 billion cut in Medicaid, of which a large portion would be reduction to states is a one-way budget cutting exercise by which negative consequences will be imposed upon states. As with just about everything, there is more than just one-side to the story, and since you are a former Governor, I think many of these points will be familiar to you.

First, the National Conference of State Legislatures has endorsed the Smith-Bingaman legislation and said, "Through deep cuts proposed this week of up to $60 billion over the next 10 years, budget negotiators may erode that partnership and pass additional costs on to the states and increase the number of uninsured….The National Conference of State Legislatures has endorsed federal legislation that would create a joint state-federal commission to examine programmatic and funding aspects of Medicaid, an important first step to a strong reform initiative."

NCSL points to a number of grievances that it calls the "Export of the Federal Deficit" to states. The following are some of their complaints and I would ask that you address whether you think, as both a former Governor and now Secretary of HHS, they have merit:

1) 42% of the costs in Medicaid are attributable to the filling gaps in the Medicare program, including benefits and cost-sharing for low-income seniors and people with disabilities. For example, Medicare has a two-year waiting period for people with disabilities, which results in many an estimated 400,000 people having to revert to Medicaid coverage while waiting for the two-year waiting period to end for Medicare. This is a direct cost shift to states and results in poor care coordination for people with disabilities.

2) The Medicare prescription drug bill requires that states make what is referred to as "clawback" payments to the federal government in what the CBO has estimated to be $88.5 billion over 8 years. States have noted with alarm that the OMB recently revised its figures from below the CBO figure to above it, and OMB now estimates the 8-year "clawback" to exceed $90 billion.

3) The Medicare prescription drug bill imposes new administrative costs on state Medicaid agencies to help make determinations of who is eligible for the low-income drug benefit in Medicare. In fact, CBO found that new Medicaid costs due to the Medicare bill are expected to exceed Medicaid budget relief during this year and next by $1.2 billion.

4) Due to a rather technical bureaucratic changes by the Department of Commerce and CMS and due to other technical factors associated with the way the Medicaid federal medical assistance percentage, or FMAP, is calculated, 29 states will lose over $850 million in FY 2006 in federal Medicaid matching payments. Of the 20 members on the Finance Committee, 14 of us represent states, including Arizona, Arkansas, Idaho, Kentucky, Maine, Mississippi, Montana, New Mexico, North Dakota, Tennessee, Utah, Vermont, West Virginia, and Wyoming, that are taking a cut in federal Medicaid dollars by a combined$422 million in FY 2006 just be this change in the FMAP.

5) The Social Security Administration has acknowledge that it has failed to timely enroll many people into the SSDI program, which leads to Medicare coverage, and so that many disabled citizens have remained on Medicaid for longer than they should have. Nobody has any idea what costs the states have absorbed by this.

As you know, these are just a small sample of the complaints the states have with how the federal government operates or, in their words, "exports the deficit" to them. Do you think these are legitimate concerns that the states have raised?

Answer:
The issues you raise make it particularly clear that the current Medicaid system needs reform. Medicaid provides health insurance for more than 46 million Americans but

states still complain about overly burdensome rules and regulations, and the state-Federal financing system remains prone to abuse. This past year, for the first time ever, states spent more on Medicaid than they spent on K-12 education. Over the next ten years, American taxpayers will spend nearly $5 trillion dollars on Medicaid in combined state and Federal spending. Over the past ten years, Medicaid spending doubled. At its current rate of growth (7.5%), the Federal share of Medicaid spending would double again in another ten years. The growth in Medicaid spending is unsustainable. But so are its convoluted rules.

With regard to the role Medicaid plays in the Medicare program particularly for individuals who are disabled but must wait twenty-four months for Medicare coverage to begin, we are bound by the requirements of the statute added in the 1972 amendments, specifically section 1811 of the Social Security Act. I understand your view that this waiting period may not be in the best interest of the beneficiary particularly as it relates to care coordination but without a statutory change I don't have the authority to change this requirement of the law.

You also raise several concerns regarding the implementation of the MMA including the so-called "clawback" and the impact of administrative costs on states. Congress clearly intended for states to get significant savings as a result of the Medicare law. The data we have continues to show that every state will come out ahead. In fact, according to our latest estimates based on actual state data, states are estimated to save about $8 billion in the first five years of the program's implementation alone (2006-2010). The sources of savings include Medicare drug coverage for dual eligibles, new subsidies for state retiree health programs, and relief for State Pharmaceutical Assistance Programs.

We want to ensure that the phase-down contribution – the so-called "clawback" – is accurate and fully reflects all appropriate state data, and that all other data related to state costs and benefits from the Medicare law are considered appropriately. To support this process, the Centers for Medicare & Medicaid Services (CMS) sent a letter to all Medicaid directors on March 28, 2005, asking them to provide data on the overall impact of the MMA on their state. CMS has been reviewing the submissions and has conducted follow-up calls with all these states to discuss their data. If any state has real concerns about savings, we've asked them to work with us to make sure we get it right.

Additionally, states can coordinate low income subsidy determination activities with the Social Security Administration (SSA). SSA is working closely with CMS and has developed a comprehensively evaluated and simple application form for the low income subsidy that states may elect to use. We believe that if states work closely with SSA it will minimize state administrative costs.

As a former Governor, I can appreciate your concerns about the impact of periodic changes in the Federal Medical Assistance Percentages (FMAPs). FMAPs are used to determine the amount of Federal matching funds for state payments for many social service programs, including Medicaid expenditures. The Social Security Act requires me to calculate and publish the FMAPs each year and the Department's Office of the

Assistant Secretary for Planning and Evaluation (ASPE) carries out this function. The methodology for calculating FMAPs is spelled out in the Social Security Act, and CMS neither furnishes the data nor calculates the formula to determine the FMAP. As required in section 1101(a)(8)(B) of the Social Security Act, the calculation is based on a three-year average of state per capita personal income, and this information is published by the Department of Commerce. I want to make it perfectly clear, however, that HHS does not have a role in supplying data for the FMAP calculation and does not exercise any discretion whatsoever in the formula for calculating FMAPs.

The concerns you raise in your question are serious. But I am hoping that the new Medicaid Commission, which I announced on May 20, 2005 and which will provide two reports to me – one this year and one at the end of 2006 – will look at each of these concerns and many others as we work together to develop recommendations that will sustain our vitally important health care safety net. We must do so by giving states the flexibility necessary to maintain coverage for those most vulnerable among us but at a cost that isn't prohibitive or sustainable.

Question 12:
At the hearing, you stated that you did not think a Medicaid Commission would produce much in the way of reform and appeared to reject that approach. Rather than raising this at the hearing, I would like to point out that you supported the formation of the Utah Health Policy Commission (HPC) when you were governor. According to a February 2003 report by the Commonwealth Fund entitled "Assessing State Strategies For Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont," the HPC was rather successful as it "recommended and supported the passage of 34 pieces of legislation before its 'sunset'."

Do you share the assessment of the Commonwealth Fund that the HPC did have some success in getting health measures enacted when you were Governor of Utah?

Answer:
Fundamentally, we believe that there is little time for delay in reforming the nation's Medicaid program. The program is in serious need of modernization to make it financially sustainable for future generations and, equally important; to ensure that it keeps pace with the many and varied needs of the different populations it serves.

Since delay is not a luxury we have, and since we already have a robust knowledge of what works though evaluations and review of the successful state-level waivers and demonstrations to reform and modernize the program-- in addition to our own analyses of program expenditures and statistical data-- we were initially reluctant to take any measure that could conceivably lengthen the process of implementing solutions to the program's problems.

However, through the budget reconciliation resolution discussions, we have reached agreement on a commission that will have two very concrete charges: developing an interim report to meet the requirements of the budget reconciliation resolution by

September 31 of this year; and making substantive recommendations for longer-term reform by December 31 of next year. The commission will not be one that *identifies problems* and leaves it at that—we all know what the problems are, from soaring state and Federal expenditures to a benefits package initially conceived in the 1960s, modified incrementally over time, which has never received a thorough review. We plan to structure the process to ensure that the commission will make substantive recommendations for positive action to improve and preserve the program, with necessarily ambitious timeframes.

As the report you cited indicated, the HPC developed policy alternatives and recommended legislative reform regarding improved access and quality and lower cost. In the end it recommended and supported the passage of 34 pieces of legislation before the committee "sunset." With its expedited timeframe, focus on finding answers as opposed to identifying already-apparent problems, and time-limited existence, we believe that there is good reason to expect that the Federal Medicaid Commission, announced May 20, 2005, can be as successful as the HPC was for my state of Utah.

Question 13:
The Administration has proposed cutting Medicaid by $60 billion by reducing the State's ability to use intergovernmental transfers from county governments to help pay the State share of funds or through the use of provider taxes. Last year, New Mexico implemented both to help keep the Medicaid cuts from being more severe than they would otherwise be, and the provider tax was recently rejected by CMS almost a full year later.

In the past, Congress clamped down on provider taxes (requiring them to be broad-based and uniform and New Mexico's are) and abuse of the Medicare upper payment limit (overpaying certain providers to draw down the federal match and asking them to rebate the overpayment back to the State). Legislation was passed on both of these matters but now the Administration wants to reopen these issues.

What exactly is the Administration's proposal? When are you proposing to implement this proposal? Will it be phased in, and under what time frame? What is the effect on state revenues as the proposal is phased in (assuming it is)? What are the state-by-state figures on impact of the Administration's proposal?

Answer:
The Administration proposes to further improve the integrity of the Medicaid matching rate funding mechanism by curbing the use of financing arrangements that states use to avoid the legally determined state match requirement. Through various mechanisms, government providers return Federal Medicaid funds back to the states. States, in turn, recycle these funds by using them to draw down additional Federal dollars. The President's Budget proposes to build on current CMS efforts to curb these questionable financing practices by matching only those funds kept by providers as payment for services.

In addition, current law allows states to make Medicaid payments to providers far in excess of the actual costs of services. States use this additional money to leverage Federal reimbursements in excess of their Medicaid matching rate or for other purposes. To avoid this misuse of funds, the President's budget proposes to limit reimbursement levels to no more than the cost of providing services.

Question 14:
It is our understanding that HHS has provided the State of Texas a letter saying that they will not be impacted by the Administration's proposal on changes to intergovernmental transfers in the budget.

Has HHS or CMS provided such a letter to Texas and other states? If so, can you provide one to the State of New Mexico?

Answer:
As part of its review of all Medicaid state plan amendments (SPAs) with reimbursement to providers and Medicaid waiver program requests, CMS has asked all states a series of questions designed to determine whether a state is appropriately sharing in the cost of its Medicaid program. CMS has applied its questions and remedies (if needed) equally across states. Where it has identified Medicaid SPAs/waivers that would create, or are dependent on, new recycling mechanisms, CMS has not approved these SPAs/waivers. If it finds a SPA that is linked to existing recycling mechanisms, CMS has asked the state to work with it to terminate such financing practices on a prospective basis with the state's next budget cycle.

CMS' correspondence to Members of the Texas Congressional delegation regarding the funding of the Texas disproportionate share hospital (DSH) program was based upon the responses received to the series of funding questions, described above, under CMS' review of Texas Medicaid reimbursement SPAs. The responses from Texas indicated that the State was appropriately sharing in the cost of the DSH payments through a combination of State and local funds with providers retaining 100 percent of the DSH payments. Based upon the responses, there didn't appear to be any recycling of Federal funds. CMS is currently in the process of verifying the responses received from Texas and other states.

CMS' correspondence with the Texas Congressional delegation, however, had nothing to do with the legislative proposals to restrict inappropriate recycling arrangements. Once again, our correspondence with respect to Texas State Plan Amendments SPAs was in response to a letter from the State's Congressional delegation.

Question 15:
I would like to ask you about the budget proposal to reduce the federal matching rate for targeted case management services from the current FMAP for a state to 50/50 nationwide. I am just asking about the change in the FMAP and not about the other policy changes that the Administration is seeking in targeted case management.

Of this cut, AARP has said, "Case management can help improve the quality of care for individual with multiple chronic conditions and may also reduce costs. This is why the federal government has historically provided states with extra support for these initiatives. Eliminating this extra support may be the kind of cut that does not produce real savings in the long run."

In fact, the FMAP change is simply a shift in costs from the federal government to the states, but what should be disturbing to many of the senators representing poorer states is that the effect is to disproportionately sock it to the poorest states in the nation to absorb the entire $4 billion in savings while wealthier states that are already at a 50/50 match will see absolutely no change or cut whatsoever to their program.

Why is the Administration targeting just the poorest states for this type of cut?

Answer:
The proposal to reimburse case management activities as an administrative service (at 50% federal financial participation) is designed to avoid cost shifting from other programs.

Case management activities are a critical part of carrying out foster care, the Individual with Disabilities Education Act (IDEA) and criminal justice programs. There is evidence to indicate that states have attempted to shift costs associated with other social service programs to Medicaid. There are instances where the Medicaid program is being charged improperly for case management services when another program should maintain responsibility for payment.

Under the proposal, the match rate for case management will be the same as it is for an administrative activity. It does not eliminate federal financial participation (FFP) for case management services, nor does it affect Medicaid eligibility for those services or any other Medicaid services. In addition, the proposal does not affect the amount of reimbursement that states will receive for Medicaid services to which an individual may be referred by a case manager.

Question 16:
The current Medicaid DSH program provides some states with DSH dollars that amount to almost 10% of the cost of their entire Medicaid programs. In sharp contrast, states like Utah, New Mexico, Iowa, and Montana, who chose not to "game the system" receive federal DSH dollars in an amount that is less than 1% of the costs of their Medicaid programs.

Currently, over $10 billion is provided annually in federal DSH dollars to states but we know very little about how that money is spent. Furthermore, there are reports about how hospitals that are receiving funding under the program either refuse treatment to indigent patients or bill them for the treatment at many times their cost.

In the budget, this issue is mentioned but there is very little in detail as to what HHS contemplates here.

Senator Smith and I are working on legislation that would take unspent DSH dollars and reprogram them to require community health centers and other safety net providers to create networks of care for the uninsured to provide the full array of treatment to patients served by community health centers. The Senate Republicans, in their Health Task Force report this year, acknowledged the problem that community health centers face in providing treatment to the uninsured but then have no referral capability, which forces the physicians to spend much of their time in the role of social workers trying to get surgical or hospital care. Considering that we are likely to do very little to address the 45 million uninsured in this country, this may at least be a way to improve care to the uninsured.

Could you provide some additional details as to how the Administration would like to change the Medicaid DSH program?

Answer:
We agree that there are more efficient ways to provide care for the indigent than through uncompensated care programs like the DSH program. We would like to see programs that provide primary care, especially programs that make use of the expertise and networks developed by safety net providers. Many of our state partners have implemented demonstration projects that we think are worthy examples for other states to consider as they assess the best way to address the problem of the uninsured in America.

The 1993 approval of the Hawaii Quest Demonstration program includes redirected DSH funds in order to provide insurance coverage rather than uncompensated care. Similar initiatives were included in the early TennCare program, New York Partnership and Vermont Health Access Program – all broad comprehensive statewide section 1115 demonstration programs that included eligibility expansions to uninsured populations. Also, more recently, CMS has collaborated with the State of Maine and the District of Columbia to reprogram DSH funds to provide health insurance instead of uncompensated care. In the Maine and District of Columbia examples the demonstration intervention is solely directed at redirecting DSH – it is not part of a larger statewide health reform initiative and the insurance outcome of redirecting DSH is easily established. These two examples have expanded insurance coverage to more than 20,000 low-income childless adults. At the start of 2004 there were 20,900 childless adults up to 100% of the Federal poverty level (FPL) insured through the program in Maine and 2,400 childless adults up to 50% of the FPL in the District of Columbia. In both of these programs the participants receive benefit of the full State Plan Medicaid benefit package.

Most recently, we approved a demonstration in the Commonwealth of Massachusetts that permits disproportionate share hospital (DSH) payments to be re-directed to pay for the costs of care of the uninsured populations outside of the hospital setting. The State will also be permitted to use these "re-directed" DSH dollars to eventually purchase health insurance coverage for some of the uninsured population in the State. By fully embracing the Federal-state partnership, CMS and the Commonwealth were able to create a

demonstration program, which will help reduce the rate of uninsured in Massachusetts. Allowing the Commonwealth to invest up to 10 percent of the Safety Net Care Pool (SNCP) for infrastructure and capacity building will now enhance the community provider network by increasing access to quality health care.

Question 17:
Along with Majority Leader Frist, I have introduced legislation (S. 1159 and S. 2091) in this Congress providing $50 million per year in funding for outreach and enrollment efforts for children's health coverage. The Administration's budget announced a $1 billion initiative in his campaign for outreach and enrollment.

We would like to work with the Administration on this initiative, including the focus that has been proposed for coverage of Native American children. I would urge a focus on Hispanic children as well, as Hispanic children have the highest rates of eligible but unenrolled children for both Medicaid and the State Children's Health Insurance Program (SCHIP).

Can you provide more details about the Administration's proposal on outreach and enrollment? Also, if the outreach dollars are to go out over two years, can you explain why there are estimated costs in years 6-10 of the budget?

Answer:
A national outreach campaign would be established. It would provide $1 billion over two years in outreach grants to states, schools, tribes and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. The new initiative will use a portion of these funds for new outreach programs at the community level to rekindle efforts to find and enroll these uninsured children. These funds would go directly to schools, community organizations, and tribes. The initiative will also include funding for a Federal outreach campaign. Finally, the initiative will reward states that are most successful in increasing enrollment by providing funding in the form of performance-based grants to states that increase health insurance coverage to children in families with income less than 200 percent of the federal poverty level.

The 10-year budget estimate includes estimated costs of providing services to children as a result of the $1 billion Cover the Kids outreach campaign.

Question 18:
The Administration through the Centers for Disease Control and Prevention (CDC) proposed a simple, but important, flexibility provision in the Vaccines for Children (VFC) program that allows the underinsured to receive immunizations not just in community health centers but also public health clinics. This change was recognized as a helpful measure to increase the immunization rate among children and I introduced legislation (S. 2272) with Senator Smith reflecting the Administration's proposal.

When you took office, Utah had one of the lowest immunization rates in the nation and you successfully worked to improve that figure dramatically. In recent years, New

Mexico's rate fell from above the national average to the 2nd worst in the nation and we worked with CDC and the Governor's Office in New Mexico to improve that rate and strides are taking place as well.

I would like to once again work with the Administration on this initiative. When would be a good time for Senator Smith and I to reintroduce this legislation?

Answer:
In addition to serving uninsured, Medicaid-eligible, Native American and Alaska Native children, the Vaccines for Children (VFC) program provides immunizations to underinsured children, whose insurance does not cover immunizations, when they are vaccinated at participating Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs). The capacity of FQHCs/RHCs to meet the needs for vaccinating underinsured children with VFC vaccine is insufficient. There are nearly 3,900 FQHCs/RHCs enrolled in VFC actively providing vaccines, and only 1,080 of these health department clinics are FQHCs.

The President's proposal would expand the VFC access points beyond FQHCs/RHCs for underinsured children by allowing them access to VFC vaccine at state and local public health clinics.

With the VFC expansion, an additional 4,125 state and local health department clinics will be able to provide VFC vaccines to underinsured children. Increasing access points for VFC eligible children will allow those who may have been previously denied vaccinations at public health clinics to be vaccinated with the full series of routinely recommended vaccines. For example, results from a January 2003 survey indicated that children in some states were denied pneumococcal conjugate vaccine at state and local health departments due to funding limitations in the discretionary Section 317 immunization grant program. Since that time, influenza and meningococcal conjugate vaccines have been added to the routinely recommended childhood immunization schedule. A follow-up survey will be needed to determine if underinsured children are also being denied these vaccines at health departments due to Section 317 funding limitations.

Question 19:
Native Americans born today suffer a disproportionate occurrence of disease and have a life expectancy six years below the U.S. average. Approximately 60 percent of Native Americans rely on the IHS to provide for their health care needs.

Unfortunately, funding for Native American health care is a national travesty. Over the years, funding for IHS has not kept pace with medical inflation and population growth. As a result, IHS services are seriously underfunded, and patients are routinely denied care. For many critical services, patients are subjected to a literal "life or limb" test; their care is denied unless their life is threatened or they risk immediate loss of a limb. Care is denied or delayed until their condition worsens and treatment is costlier or, all too often, comes too late to be effective. Federal per capita funding for Indian health is only

$1,914, about half the allotment of federal per capita funding for health care for federal prisoners.

Secretary Thompson was out to the Navajo Reservation last year and saw the problem first-hand and vowed to fight for increased funding for tribal health care. Unfortunately, the Administration has proposed a rather modest increase of less than 2% for IHS in FY 2006. Yet again, IHS funding will not come close to keeping pace with medical inflation, which is growing at double-digit levels in the private sector.

On a per capita basis, it is even worse because your own budget documents indicate that you anticipate that IHS will have to serve over 29,000 new people. Furthermore, although urban Indians represent around half of all Native Americans in the country, urban Indian health programs receive less than 1% of all IHS funding and those funds are literally frozen at $33 million nationwide.

This is unacceptable and unsustainable and I urge you, as a former Governor of a State familiar with tribal issues, to push the Administration and OMB to, as Secretary Thompson said he was going to do, and push additional funding for IHS. I think seeing is understanding and would like to take this opportunity to invite you to New Mexico, just as Secretary Thompson recently did, and see firsthand the deplorable circumstance that the IHS system is in. I urge you to bring along OMB staff as well.

Also, at the hearing, you stated that the IHS budget is increasing by 5% rather than the 2% I stated. However, on page 22 of the *Department of Health and Human Services Budget In Brief: Fiscal Year 2006* glossy report it reads, "The FY 2006 budget request is $3.8 billion, a net increase of $72 million over FY 2005." Since FY 2005 spending was $3.774 billion and the FY 2006 budget line is $3.846 billion, that amounts to a 1.9% increase, according to our calculations.

Do you agree with that calculation?

Answer:

The President's Budget request for the IHS includes a net increase of $72 million program level, an increase of 1.9 percent over FY 2005. Additional funding is targeted to Clinical Services to maximize the provision of health services. The Clinical Services portion of the IHS budget includes a program level increase of $128 million or 5 percent over FY 2005. This increase is directly related to the Tribe's priorities as articulated at the FY 2006 Regional Consultation sessions and the Department of Health and Human Services (HHS) Budget Consultation session. At those meetings, Tribes requested funding for pay costs, population growth, contract support costs, and contract health services. These priorities are reflected in the FY 2006 request.

Question 20:
At the hearing, I asked what we could do to fundamentally improve the health care financing situation for the Indian Health Service and the discussion moved to what

percentage increase the budget provided. Whether 2% or 5%, funding for IHS, including urban Indian health care, is unacceptably low and we need a completely new model and funding mechanism for IHS.

You made a few comments on this point, but can you please elaborate on how we can work together to address this funding crisis in Indian Country?

Answer:
The FY 2006 budget request for IHS totals $3.8 billion, a net increase of two percent over FY 2005 and twenty percent since FY 2001. The budget request includes an additional $80 million for inflation and population growth, the top priorities identified by Tribes during the Department's budget consultation process. These funds, along with the $32 million requested for increased pay costs of IHS and Tribal staff, will support the provision of additional health services such as 116,000 additional outpatient visits in IHS and Tribally operated health facilities and 4,200 additional days of inpatient treatment for alcohol and substance abuse. An increase of $33 million is included to staff six new outpatient facilities. When fully operational, these facilities will increase the number of primary care visits that can be provided at these sites by nearly 75 percent and allow for the provision of new services such as 24-hour emergency rooms and upgraded diagnostic imaging and laboratory services. As I become more familiar with these issues, I look forward to seeing what else can be done to improve the delivery of health services to Indian Country.

Question 21:
At the hearing, I mentioned a letter that I sent you on February 2, 2005, regarding the situation at the Albuquerque Indian Health Center (AIHC).
Can you provide me with a status of that letter?

Answer:
I responded to your letter on March 24, 2005.

The Honorable Jim Bunning

Question 1:
A lot has been said about the new cost estimates for the Medicare prescription drug benefit. I certainly realize that the new estimate includes a full 10-year window of providing drug benefits and growth of the Medicare population. In your testimony, you mentioned another reason for this increase which is an anticipated increase in average drug spending.

Can you explain this? Also, what should Congress be doing to keep drug spending down?

Answer:
The CMS' estimates for the cost to the Federal government for the Medicare Prescription Drug program have remained virtually unchanged since the program was enacted. The Medicare Actuaries originally projected that the benefit would have a net cost to the federal government of about $511 billion over the period 2004-13. Their current projections are now about $518 billion for the same period. The estimates in the President's budget now include two additional years of drug coverage, from 2006 through 2015. With more beneficiaries using more drugs in these years, the net cost is $724 billion. The actuaries' updated estimates for individual years are not significantly different from their original estimates. In the wake of the MMA, the actuaries conducted a technical review of their estimates in consultation with outside experts and that review largely ratified their methods. A few individual elements shift slightly, but the new year-to-year estimates were within about one percent of the old.

Medicare will implement the drug benefit to provide access to up-to-date, medically necessary drugs at the lowest possible cost. The lower drug prices through price negotiation by drug plans, combined with other effective steps to manage drug costs, will lead to an estimated savings of 25 percent of drug costs compared to retail price levels - allowing beneficiaries to get much better access to medicines while still reducing overall drug spending by seniors. Analysis by both CBO and Medicare has concluded that the steps being used to implement the drug benefit lead to substantial cost savings – both CBO and the CMS actuaries have estimated that a centralized drug benefit, with government price negotiation, would not yield lower drug costs compared to current law. Moreover, government controls could restrict access to needed medicines.

Medicare is also providing new access to coverage that provides coordinated care, helping beneficiaries use medicines more effectively to prevent hospitalizations and other costly medical complications. In addition, Medicare is implementing many other provisions of the Medicare law like competitive bidding for services, lower payments for drugs, and an income-related Part B premium. All of these steps provide a stronger foundation to keep Medicare sustainable.

Question 2:
The FY06 budget projects that 16% of beneficiaries are expected to enroll in a Medicare Advantage plan in 2006, and about 25% are expected to be enrolled by 2010. Have the enrollment projections for the Medicare Advantage plans changed from when the bill was signed into law in December 2003?

Answer:
When the Medicare Modernization Act was signed into law, we were assuming that 22 percent of Medicare beneficiaries would enroll in a Medicare Advantage plan in fiscal year 2006. By 2010, 32 percent of beneficiaries were assumed to be enrolled in Medicare Advantage plan. The 2004 Medicare

Technical Review Panel reviewed this assumption and thought that the ultimate penetration rate of 32 percent was reasonable, but that we would reach that rate more slowly and over a longer period. As a result of that recommendation, the President's Fiscal Year 2006 Budget projects that 16 percent of beneficiaries will enroll in Medicare Advantage plans in fiscal year 2006. That percentage is projected to grow to 25 percent by 2010 and ultimately to 32 percent by 2016.

Question 3:
Also, it seems to me that Medicare Advantage plans offer beneficiaries an opportunity to save on their overall health costs and receive top quality care. Can you remark on this?

Answer:
Because of the MMA we project that, for the first time in the history of the Medicare program, all beneficiaries will have access to modern integrated health benefits through Medicare health plans, including preferred provider organization (PPO) plans with drug coverage. The new regional PPO plans will be similar in design to plans available to Federal employees and many millions of privately insured Americans under the age of 65. PPO plans are the most popular plan choice for Americans who have access to them, because they offer the advantages of cost savings from coordinated-care networks combined with the ability to obtain coverage for services from any provider. Until now, few Medicare beneficiaries have had access to PPO plans.

In addition to the introduction of new PPO regional plans, because of the MMA we expect more beneficiaries to have access to local coordinated-care plans, as well as private fee-for-service plans and other innovative plans such as medical savings account plans. Medicare Advantage plans have been preferred by millions of seniors because they offer lower costs (overall savings for the Medicare and non-Medicare benefits of over $700 per year in out-of-pocket costs for the average beneficiary and nearly $2,000 in savings for those beneficiaries in poor health) compared to traditional Medicare for beneficiaries who do not have supplemental coverage from an employer or Medicaid.

Question 4:
I also very alarmed about spending increases in the Medicaid program. Already, Medicaid comprises 30% of HHS spending, and many states, including Kentucky, face a shortfall.

You mentioned in your testimony that Medicaid spending has doubled over the past 10 years and is expected to double again if it continues to grow at its current pace. The Administration has proposed some legislative changes that are expected to save about $60 billion over the next 10 years, but it seems that we've got to do more if we want to control Medicaid growth.

What are your suggestions to Congress on how we can contain Medicaid spending over the long-term at both the federal level and at the state level?

Answer:
Medicaid provides health insurance for more than 46 million Americans but states still complain about overly burdensome rules and regulations, and the state-Federal financing system remains prone to abuse. This past year, for the first time ever, states spent more on Medicaid than they spent on K-12 education. Over the next ten years, American taxpayers will spend nearly $5 trillion dollars on Medicaid in combined state and Federal spending. Over the past ten years, Medicaid spending doubled. At its current rate of growth (7.5%), the Federal share of Medicaid spending would double again in another ten years. The growth in Medicaid spending is unsustainable.

The President proposes to give states more flexibility in the Medicaid program in order to enable states to increase coverage using the same Federal dollars. The tools we have at our disposal today were not available when Medicaid was created. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. The Administration has begun and will continue a serious discussion with Governors and Congress to decide the best way to provide states the flexibility they need to better meet the health care needs of their citizens.

To accomplish these goals, I believe success in reforming the Medicaid program has three components.

First, we must keep faith with the commitment this nation has made to provide access to acute and long-term care services to people with low incomes, disabilities, the elderly, and children.

Second, we must create enough flexibility in Medicaid that states are able to continue serving optional groups and expand the number of people they serve.

Third, we must assure the financial sustainability of Medicaid by returning integrity to the funding partnership.
I also would like to suggest three changes to Medicaid to help us meet these goals and to make the program sustainable into the future.

We must find every inefficiency because waste means covering fewer people. By way of example, we must stop overpaying for prescription drugs. Pharmacies and Medicare buy drugs wholesale for a low price. But under Medicaid, state governments usually pay a much higher price. The law should be changed so that states pay the same low rate. This will save the federal government $15 billion over the next ten years. It will save state governments $11 billion.

Medicaid must not become an inheritance protection plan. Right now, many older Americans take advantage of Medicaid loopholes to become eligible for Medicaid by giving away assets to their children through estate planning. There is a whole industry that actually helps people shift costs to the taxpayer. There are ways families can preserve assets without shifting the costs of long-term care to Medicaid. These loopholes should be closed and we should focus Medicaid's resources on helping those who really need it. Doing so will save $4.5 billion during the next decade.

We must have an uncomfortable, but necessary, conversation with our funding partners, the states. State officials have resorted to a variety of loopholes and accounting gimmicks that shift the costs they claim to pay to the taxpayers of other states. If we don't close these loopholes, we project that over the next ten years they will shift $40 billion through various means.

By accepting these challenges, we can ensure that seniors and people with disabilities get long-term care where they want it. The President's New Freedom Initiative points us in the right direction. Home care and community care can allow many Americans with disabilities to continue to live at home, where they can enjoy family, neighbors, and the comfort of familiar surroundings. Additionally, it frees up resources that can help other people.

We can expand access to more children. But the principles will be the same. We can provide access to more needy people by providing common sense flexibility. And the President proposes to spend $1

billion in outreach funds to find children currently eligible for Medicaid and SCHIP enrolled, and over $10 billion over 10 years to care for them.

Finally, we can improve coverage of optional populations. Whether it's a lady in a nursing home or a boy in a wheelchair, we have a very special obligation to our neighbors who are elderly, low-income, or have disabilities. We meet that obligation by providing a comprehensive package of benefits and services. Mandatory populations need the help. They must receive the help. The optional populations, on the other hand, may not need such a comprehensive solution. Many of them are healthy people who just need help paying for health insurance. We've already proven a way to provide that help. The State Children's Health Insurance Program (SCHIP) has allowed 6.1 million children (6.1 million is the most recent official number from CMS, from 2004.) in low-income families who don't qualify for Medicaid to have health insurance. One of the key reasons SCHIP has been such a resounding success is that it allows states to ask the question, "What is quality basic health coverage?" And each state can choose from five answers: the health benefits state employees get, the benefits federal employees get, the best private health plan in their state, Medicaid, or some hybrid of private and government plans. Fewer than 20 states and territories chose the straight Medicaid option. A majority chose some other combination. It costs states less, on average, to provide health insurance than to provide comprehensive care. SCHIP is a proven model on which to base a discussion of how to best structure coverage for optional populations.

The Honorable Mike Crapo

Question 1:
The Hospital Insurance (HI) Trust Fund currently fails the Medicare Trustees test for both short-range and long-range financial adequacy and is pegged to be exhausted by 2019. In 2004 HI expenditures exceeded income and required interest earnings to be used to pay benefits—this deleterious financing scheme is expected to continue.

Over the next decades, the sources required to finance Medicare shift dramatically. As a share of non-interest Medicare income, revenue from taxes will decline over the next several decades while general fund transfers must massively increase. As a share of GDP, Medicare expenditures represented 0.7 percent in 1970, 2.7 percent of GDP in 2004, and are expected to climb to 13.8 percent by 2078.

As you are aware, the Medicare Modernization Act of 2003 requires the Medicare Trustees to look out seven years and evaluate this shift in financing to determine when projected general revenue funding exceeds 45 percent of total Medicare outlays. By all accounts, the 2005 Trustees Report will determine that this 45 percent level will arrive in 2012. Also according to the Medicare law, if two consecutive reports make this 45 percent determination, then a "Medicare finding warning" will be triggered requiring the President to submit to Congress within 15 days of the next budget submission legislation rectifying Medicare so that the 45 percent threshold will no be exceeded.

Thus, by this time in 2007, the President probably will have submitted legislation proposing massive Medicare expenditure reductions or massive revenue increases, and this committee will have to take up such legislation.

Mr. Secretary, what can we do now to begin to address Medicare's long-term financing problems?

Answer:
This Administration is committed to strengthening Medicare's long-term financial security. Currently, Medicare pays all health care providers equally for the same services, regardless of the quality of services provided. The Administration has created several initiatives to collect data on quality measures from Medicare providers, including nursing homes and home health agencies, and soon hospitals, in order to hold them accountable by making these quality measures publicly available. Collecting this data can improve Medicare payments for high-quality care. Furthermore, this Administration will explore provider payment reforms that link quality to Medicare reimbursement in a cost neutral manner.

The Department of Health and Human Services (DHHS) is also developing and testing multiple strategies to improve the coordination of Medicare services for beneficiaries with chronic conditions. All of these programs have as their goal, improving beneficiary quality of life and quality of care, while reducing Medicare programs costs as well as beneficiary medical costs.

These programs include the following:

- The Care Management for High Cost Beneficiaries (CMHCB) demonstration to begin in the fall 2005.

- The ESRD Disease Management demonstration beginning in early 2006.

- The BIPA Disease Management demonstration, which includes prescription drug coverage, began enrolling beneficiaries in February 2004.

- The Coordinated Care demonstration which began in 2002 in 15 sites and certain sites will be extended to operate for another 2 years.

- The Physician Group Practice demonstration beginning this year which will provide physician groups an opportunity to demonstrate that improving care in a proactive and coordinated manner also saves money and will reward physicians who do so.

- The Care Management Performance demonstration beginning this year, which will test methods to promote the use of health information technology for improving the quality of care.

- The Medicare Chronic Care Improvement Program, mandated by the MMA and Medicare's first large-scale permanent pay-for-performance program to reduce health risks for defined populations of chronically ill beneficiaries.

The rationale for many of these pay-for-performance and disease management demonstrations includes the following:

- Beneficiaries with a few chronic illnesses account for a high proportion of total Medicare expenditures, primarily due to repeated hospitalizations.

- Beneficiaries with chronic illnesses receive too little education about their condition and appropriate self-care, and their treatment often does not follow the recommendations of evidence-based clinical practice guidelines. Their care is often fragmented and poorly coordinated across multiple provider types and settings.

- Beneficiaries who are of highest risk and incur the highest medical costs do not receive care in non-acute care locations such as the beneficiary's home, which could significantly improve the beneficiary's quality of life while simultaneously reducing costs.

The above problems are particularly apparent in the fee-for-service environment where the suboptimal frequency, timing, mix, and intensity of services provided to these patients often lead to poor clinical outcomes, dissatisfaction with care, and higher costs both to individual beneficiaries and to the Medicare program.

A study entitled, *Best Practices in Coordinated Care* conducted by Mathematica Policy Research, Inc., in March 2000, and submitted as a report to HCFA (now CMS) suggests that effective care coordination and disease management programs can significantly improve care and reduce costs. They accomplish this by improving one or more of the following: (1) patient self-care through education, monitoring, and communication; (2) physician performance through feedback or reports on patient progress; (3) communication among providers and coordination of services; and (4) access to services, including preventive services and transportation.

Question 2:
When Congress included certain chronic care initiatives as part of the Medicare Modernization Act, I was very hopeful that that all three specifically referenced chronic illnesses—heart failure, diabetes and chronic obstructive pulmonary disease (COPD)—would be included in the Department's eventual plans and receive the attention all three deserve. COPD, the 4th leading cause of death in the U.S., is ripe for a well designed chronic care initiative that can actually save Medicare dollars. As the co-Chair of the Congressional COPD Caucus, it is disheartening to learn that COPD is not included if any of the 10 Voluntary Chronic Care Improvement Program's Phase-1 awardees.

What can you offer to the Congressional COPD Caucus and my colleagues as reassurance that this will be remedied in a very timely manner?

Answer:
The goals for the 9 Voluntary Chronic Care Improvement Programs include:
offering self care guidance and support to chronically ill beneficiaries to help them manage their health; adhering to their physicians' plans of care; and assuring that they seek (or obtain) medical care that they need to reduce their health risks.

The initial programs are focused on beneficiaries who have Complex Diabetes or Congestive Heart Failure (CHF) because theses beneficiaries have heavy self-care burdens and high risks of experiencing poor clinical and financial outcomes. Chronic Obstructive Pulmonary Disease (COPD) was included on our solicitation for participation, but was not among the strongest proposals that were competitively reviewed. However, the initial programs selected are designed to help participants manage all their health problems and co-morbid conditions, including COPD.

The Honorable John F. Kerry

Question 1:
How many children do you estimate will receive health insurance coverage under your "Cover the Kids" initiative? What assumptions are made in calculating this estimate?

Answer:
Estimates made by various organizations put the number of uninsured children at 9 million. It is expected that three quarters of those could be eligible for Medicaid or SCHIP. The innovative approaches included in the President's FY 2006 budget will work to reduce that number.

Question 2:
How many low-income uninsured do you estimate will get coverage under the refundable tax credits for high deductible health plans? How many people who are already insured do you estimate will benefit from the tax credits for higher income earners?

Answer:
The health insurance tax credit proposal will benefit up to 4.6 million Americans who would otherwise not have coverage. The health insurance tax credit proposal provides a subsidy for low-income individuals with modified income of less than $30,000 and families with modified income of less than $60,000. These eligible individuals and families have the option of using their tax credits to purchase a high deductible health plan (HDHP) and contribute to an HSA or to use their tax credits to purchase non-HSA eligible health coverage. The health care tax credit is only for lower-income individuals and families, who are unlikely to be eligible for subsidized employer-sponsored health insurance.

The Honorable Blanche L. Lincoln

Question 1:
Secretary Leavitt, the President's budget eliminates 28 health programs that have made a profound difference in the lives of many Arkansans. One of these programs is the Arkansas Geriatric Education Center, whose mission is to train and educate practicing health professionals, students, and faculty in geriatrics. This program has been a tremendous asset to thousands of health professionals in Arkansas. With its elimination, there will be even fewer people trained in geriatrics. Given the aging of our population, why would you eliminate this program when it's so essential to training our health care workforce in geriatrics? There are no other programs that provide geriatric training, so it's not a duplicative program. And training our health care professionals in geriatrics should be a huge priority for our society today given the fact that the first of the 76 million Baby Boomers will turn 65 in six years. Why did you eliminate this program?

Answer:
The Geriatric Education and Training Programs are relatively small efforts that can and do secure support from other sources of funding, including States and other Federal programs such as the Veterans Administration and Centers for Medicaid and Medicare Services. The number of primary care physicians and physician assistants has grown significantly over the past decade. In addition, salaries and economic incentives for primary care providers have also increased. The General Accountability Office (GAO) reported in 2003 that the U.S. physician population increased by 26 percent, which was twice the rate of growth of the total population, between 1991 and 2001. Many of the Health Professions programs were created in response to an anticipated national shortage of physicians – that shortage does not exist. While geographic disparities persist, growth was seen in historically high-supply metropolitan areas as well as low-supply statewide non-metropolitan areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefited from the program's long-term training support in 1991 to 2001 did not practice in shortage areas. The GAO also concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Question 2:
The administration now estimates that the new Medicare drug benefit will cost $720 billion from the years 2006 through 2015. Dr. McClellan said last week that the new estimate covers two additional years, when Medicare enrollment will be larger and drug prices will be higher. He also said that in 2015 alone, Medicare will spend well over $100 billion on the drug benefit. Does the administration have any suggestions on how to control escalating drug costs? Do you think we can sustain these kinds of costs in the Medicare program? Would you consider MedPAC's findings that Medicare has overpaid managed care plans in Medicare and propose cutting those overpayments? I would hope that you would also consider ways to help Medicare better coordinate the care for the 5 percent of seniors in Medicare who use 50 percent of it funding. I believe better coordination would help doctors avoid over-prescribing medications and cut costs by

eliminating duplication of services. I have a bill, the Geriatric and Chronic Care Management Act, which seeks to save money through coordination of care.

Answer:
The CMS' estimates of the cost to the Federal government for the Medicare Prescription Drug program have remained virtually unchanged since the program was enacted. The Medicare actuaries originally projected that the benefit would have a net cost to the federal government of about $511 billion over the period 2004-13. Their current projections are now about $518 billion for the same period. The estimates in the President's budget now include two additional years of drug coverage, from 2006 through 2015. With more beneficiaries using more drugs in these years, the net cost is $724 billion. The actuaries' updated estimates for individual years are not significantly different from their original estimates.

Medicare will implement the drug benefit created by the MMA to provide access to up-to-date, medically necessary drugs at the lowest possible cost. The lower drug prices through price negotiation by drug plans, combined with other effective steps to manage drug costs, will lead to an estimated savings of 25 percent of drug costs compared to retail price levels - allowing beneficiaries to get much better access to medicines while still reducing overall drug spending by seniors. Analysis by both CBO and Medicare has concluded that the steps being used to implement the drug benefit lead to substantial cost savings – both CBO and the CMS actuaries have estimated that a centralized drug benefit, with government price negotiation, would not yield lower drug costs compared to current law. Moreover, government controls could restrict access to needed medicines.

The MMA also gave the Secretary of Health and Human Services several tools to attract and retain regional Preferred Provider Organization (PPO) plans throughout the country as part of the Medicare Advantage (MA) program. The MA payment structure was designed by Congress to maximize plan choices for beneficiaries, especially in rural parts of the country where plans had previously not been offered. These plans will be able to offer better benefits and more coordinated care than traditional Medicare at a lower cost to beneficiaries.

Medicare is also providing new access to services that coordinate care, helping beneficiaries use medicines more effectively to prevent hospitalizations and other costly medical complications. In addition, Medicare is implementing many other provisions of the Medicare law like competitive bidding for services, lower payments for drugs, and an income-related Part B premium. All of these steps provide a stronger foundation to keep Medicare sustainable.

Question 3:
Can you update me on the status of the Medicare Care Management Performance Demonstration (Section 649) in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003? The language makes clear that one of the demonstrations should take place in Arkansas, and that this demonstration has a special rule which specifies that patients there have two or more chronic conditions, including dementia.

How will you implement this special rule in Arkansas? My goal when writing this language was to ensure that patients treated there would have multiple chronic conditions (thus the language "two or more chronic conditions") and dementia.

Answer:
Section 649 of the MMA requires the Secretary to establish a 3-year pay-for-performance pilot with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive a bonus payment for managing the care of eligible Medicare beneficiaries.

The legislation also required that the Secretary designate no more than 4 sites at which to conduct the demonstration program under this section, of which

(A) 2 shall be in an urban area;
(B) 1 shall be in a rural area; and
(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

The states chosen for the demonstration are California, Utah, Massachusetts and Arkansas, with Arkansas fulfilling category (C) as described above.

Although category C states that the Department of Geriatrics must be able to treat dementia, the specific clinical measures to be used in the demonstration reflect process and outcome measures in the treatment of coronary artery disease, congestive heart failure, hypertension, and diabetes mellitus. In accordance with the statute, the Medical School Department of Geriatrics must be capable of managing patients with multiple chronic conditions, one of which is dementia. We understand that the University of Arkansas meets this requirement. We also understand that physicians associated with the University of Arkansas will be able to treat patients with multiple chronic conditions, including dementia. However, we also expect that many of the geriatric patients in the demonstration will have multiple chronic conditions other than dementia, and are not planning to exclude the treatment of patients who do not have dementia. It is our intent to provide incentives for the best quality of care to Medicare beneficiaries, including those with dementia.

Question 4:
In previous statements before this Congress, your predecessor Secretary Thompson was very strong in saying that Medicare Part D plans would not be able to use differences in prescription cost sharing to steer beneficiaries to mail order pharmacies and away from local retail pharmacies to obtain their prescriptions. Yet, the final regulations seem to reverse this position and allow plans to charge Medicare beneficiaries lower cost sharing at mail order than at retail. Has the Administration changed its position on this issue, and how will you guard against Part D plans trying to shift prescriptions away from retail pharmacies to mail order?

Answer:
The MMA's "level playing field" provision in 1860D-4(b)(1)(D) prohibits Medicare drug plans from requiring beneficiaries to use mail order pharmacies. It allows Medicare beneficiaries to receive extended supplies of drugs at retail settings, but they must pay "any differential in charge" between retail and mail order. Our understanding of the statutory language is that the beneficiary is allowed the choice, which may entail higher costs, but the plan (and the government) pay what we would have paid if the drug were delivered in the lowest-cost setting. We also understand that it is important to maintain the personal contact that patients have with their local pharmacist, from whom they can receive counseling and answers to their health questions.

The statutory term "charge" is actually quite general and can encompass a variety of individual charges that affect both total cost and how much a beneficiary pays at the pharmacy counter. For example, the price of the drug (its ingredient cost) often varies between retail and mail order, as does the dispensing fee. Mail order facilities are highly automated and generate much lower per-unit dispensing fees. It is common in the commercial market today for plans to offer lower cost-sharing on drugs provided by mail order. The proposed rule did not specifically address differences between mail order and retail cost sharing. The final rule did address the situation by allowing plans to charge "any higher cost sharing applicable" to retail, compared to mail order. After publishing the final rule, CMS also issued additional guidance to plans to instruct them how this level playing field rule should be reflected in their contracts with pharmacies. As part of that guidance, CMS encouraged plans to allow pharmacies the opportunity to match the mail order rate completely in the retail setting, which would result in no cost sharing difference for the beneficiary. Barring that, under CMS guidance, pharmacies could partially match the mail order rate, which would require the beneficiary to make some extra payment to receive an extended supply at retail.

We believe the final rule, coupled with the guidance, reflects the statutory intent that plans be able to provide and beneficiaries to receive their drugs in the lowest cost setting, but also allows beneficiaries the opportunity to receive extended supplies at retail.

Question 5:
After reading the final Part D regulations, I am concerned that Medicare beneficiaries will be economically penalized if they want to obtain their prescriptions at their local retail pharmacy. First, the final regulation allows plans to designate certain pharmacies as "preferred" in their pharmacy network, and then allows them to charge higher cost sharing to beneficiaries if the pharmacy they use is designated a non-preferred. Then, they allow plans to charge higher cost sharing for a beneficiary to use a retail pharmacy rather than a mail order pharmacy. I believe this program will be successful only if we give beneficiaries a fair choice of where they want to obtain their medications, and I am concerned that beneficiaries will be confused by this system. Also, I am concerned that this program will hurt small, rural pharmacies if they cannot fill prescriptions for Medicare beneficiaries because seniors are given financial incentives to use mail order pharmacies. How do you react to these concerns? Will you give this Committee your

commitment to not approve any Part D plan that makes it economically difficult for Medicare beneficiaries to use the local retail pharmacy of their choice?

Answer:
I want to assure you that I consider community pharmacies to be an important partner in making the drug benefit successful and providing needed medications to our 41 million elderly and disabled beneficiaries.

The MMA has several related provisions that are important to note here. First, the law requires plans to construct a broad network of retail pharmacies that provide convenient access to Medicare beneficiaries. In the CMS regulation, we defined this convenient access standard as per the TRICARE standard: in urban areas, the network must be broad enough so that 90 percent of beneficiaries live within 2 miles of a network pharmacy; for suburban areas, 90 percent must live within 5 miles, and for rural areas 70 percent must live within 15 miles. We believe that this standard will serve residents of cities and rural areas very well and will generate broad participation by pharmacies.

Second, the law allows any pharmacy willing to meet a plan's terms and conditions to join that plan's network, so even if a plan does not need to include a particular pharmacy in order to meet the convenient access standard, the pharmacy has an opportunity to participate. Finally, as you suggest the law also allows plans to set up preferred pharmacies that feature reduced cost sharing for beneficiaries.

We believe that our regulations properly reflect these three provisions and will provide convenient access to all Medicare beneficiaries.

Let me address your concern that the preferred pharmacy provision could negatively impact small rural pharmacies. In practice, there will be several constraints on the plans' use of this preferred pharmacy option. To start, CMS will thoroughly review the plans' proposals for preferred networks to make sure that no geographic discrimination will occur. For example, CMS would not allow plans to construct a preferred network that favored cities over rural areas or that concentrated preferred pharmacies in certain parts of a state. This review is consistent with a general rule in the Medicare drug benefit that no plan feature can be designed with discrimination in mind, to either encourage or discourage certain groups of beneficiaries from enrolling. Finally, there is a significant constraint on the cost sharing differential that plans can establish to encourage people to use their preferred pharmacies. In their bids to CMS, plans have to show that their co-pays or co-insurance percentages during the drug benefit's initial coverage phase average out to 25 percent of the cost of the drugs. This average covers the plans entire expected utilization, so it includes not just generic, preferred brand and non-preferred brand co-pays but also those co-pays in preferred and other pharmacies. This means that when a plan features lower co-pays at preferred pharmacies, this would tend to lower the average. Mathematically, there are strong limits on how big a co-pay difference the plan can set up and still meet that 25 percent average overall.

As for mail order, while we believe that mail order can present a choice in delivery options for cost-effective alternative to deliver chronic, recurring medications, Medicare plans will not be allowed to *require* that beneficiaries use mail order pharmacies to get extended supplies of drugs. We recognize that local pharmacies play a valuable role beyond just dispensing drugs – they provide countless hours of counseling and answer countless questions on the proper use of that medication. The MMA has a specific provision allowing Medicare beneficiaries to receive a 90-day (or other extended) supply of their medication at a retail pharmacy. The law also notes that the beneficiary has to pay any differential in charge between retail and mail order. In recently released guidance, CMS clarified its final rule to show that retailers will be given an opportunity to match the mail order price, further encouraging beneficiaries to fill the prescription in their local store. We will work with plans and retailers to help make this happen.

Question 6:
I understand the President's budget would provide significant resources to CMS for implementation of the MMA and related education and outreach to beneficiaries. These resources will be largely targeted at the majority of Medicare beneficiaries who are ambulatory. However, special efforts will be needed to assist institutionalized dual eligibles and individuals with cognitive impairment in the transition to Part D coverage. These vulnerable patients have more complex medication regimens and will require focused resources to accomplish the transition. How will you ensure adequate resources are available through CMS or other HHS agencies with relevant expertise, such as SAMHSA, to address this critical need?

Answer:
CMS currently partners with several Federal and State agencies that reach older and disabled persons and their families. These include the Administration on Aging, the Indian Health Service, the National Cancer Institute, the Office of Personnel Management, the Social Security Administration, and the Department of Agriculture, Cooperative State Research, Education and Extension Service. This cooperation promotes consistent messages between the agencies and ensures the efficient use of resources.

Due to the unique needs of institutionalized beneficiaries and beneficiaries with cognitive impairments, CMS made special efforts to reach out to this vulnerable population. Among others, the Substance Abuse and Mental Health Services Administration (SAMSHA) has been a key CMS partner in these outreach efforts. Pursuant to an interagency agreement, CMS and SAMSHA worked together to develop materials and coordinate outreach activities. In addition, CMS has been working with state and local health agencies and disability organizations to reach institutionalized beneficiaries and those with cognitive impairments. Examples of organizations CMS has collaborated with include the National Mental Health Association, National Alliance for the Mentally Ill (NAMI), National Council for Community Behavioral Healthcare, and the National Association of State Mental Health Program Directors. CMS offered training and materials to these organizations to supplement the substantial outreach activities conducted by the CMS regional offices.

CMS is aware of the unique needs of those who are cognitively impaired and suffer from mental illnesses and we taken special efforts to target this vulnerable population. CMS currently partners with several Federal and State agencies that reach those older persons with mental illness and their families which includes the Substance Abuse and Mental Health Services Administration (SAMSHA). CMS has an interagency agreement with SAMSHA on developing materials and coordinating outreach to those beneficiaries with mental illnesses.

CMS has been in regular contact with health agencies and disability organizations sending them information on the Part D program. These organizations include National Mental Health Association, National Alliance for the Mentally Ill (NAMI), National Council for Community Behavioral Healthcare, and the National Association of State Mental Health Program Directors. We have also provided training to these organizations, if needed on the Part D program. Also, CMS regional offices have representatives that are designated to work on the Campaigns with the Campaigns, specifically targeting those with a disability or mental health needs. These regional representatives conduct outreach activities at the local level.

Question 7:
There is no comprehensive long term care system that serves the needs of the elderly and disabled in the United States other than Medicaid. Unless we encourage Americans to plan ahead, demand and costs for long term care services could deplete their savings and exhaust government programs. Last year, the President's budget included a proposal to provide an above-the-line deduction for long-term care insurance. Why did the administration omit this proposal from the President's budget this year?

Answer:
Given the concern for the budget deficit, the proposals that had the best prospects of achieving their goals were kept. The above-the-line deduction for long-term care insurance is a very expensive proposal and the proposed deduction would create a loss in tax revenue that would exceed any Medicaid savings within the budget period 2006-2015.

Question 8:
I'd like to hear how you envision implementing the proposals laid out in the President's budget. My state of Arkansas is deeply concerned about this because they stand to lose a tremendous amount of funding. They depend on Medicaid funding to provide care to one in five Arkansans. This funding pays for over half of the births in our state. Over half of all children in Arkansas are either on Medicaid or received Medicaid services at some point during the year. I agree in strengthening the integrity of the program but not at the risk of depriving people of the health care they need.

You cannot cut millions and millions of dollars overnight and not avoid this risk. Please explain more about how you plan to implement these changes.

Answer:
The Administration's budget proposals are designed to curb abuse of the Medicaid program without sacrificing the program's commitment to serve vulnerable populations in need of care. The President's Budget seeks to build on current CMS efforts to curb questionable financing practices used by states to avoid the legally determined state match requirement and to ensure that individuals who can afford to pay for some or all of their long-term care needs do so. However, I recognize the importance of ensuring that efforts to improve the integrity of the Medicaid program do not inadvertently harm needy recipients. Therefore, the Administration has agreed to the formation of a Commission to study the need for savings in the Medicaid program and how best to implement reforms so that coverage and the accessibility and quality of care are not adversely impacted.

Question 9:
Mr. Secretary, the Administration indicates in its proposed budget that it wants to move to Average Sales Price (ASP) for Medicaid pharmacy reimbursement. I have had heard serious concerns from my pharmacies in Arkansas that this would be devastating for them because retail pharmacies purchase at the higher end of all pharmaceutical purchasers, and would often be significantly be reimbursed below cost under this system. That is because ASP is based on an average selling price among all purchasers. I am also concerned that pharmacies would be able to participate in Medicaid, making it difficult for Medicaid recipients in my state to find a place to fill a prescription. Why did the Administration propose ASP for Medicaid, given that ASP doesn't really represent the prices at which retail pharmacies buy pharmaceuticals? Does the Administration envision paying pharmacies a better dispensing fee for providing Medicaid prescriptions, and if so, how much?

Answer:
Under the flexibility allowed in current law, most Medicaid agencies reimburse pharmacies based on the Average Wholesale Price (AWP). AWP is a list price that is set by the drug manufacturer for their product. However, pharmacies acquire the drugs from the manufacturer for a cost that is usually much lower than the AWP. The difference between the pharmacy acquisition cost and the AWP is referred to as the "spread". The larger the "spread" the more a pharmacy profits on the reimbursement from Medicaid. This system has created an incentive for manufacturers to artificially raise the AWP to make their products more attractive to pharmacies because the profit will be larger with the higher AWP.

The President's FY 2006 budget proposes a system that more closely aligns pharmacy reimbursement with pharmacy acquisition cost by using the average sales price as the basis for Medicaid payment for drugs. Drug manufacturers would be required to submit this price to CMS. State would pay, on an aggregate basis, no more than this price plus a 6 percent markup to reflect additional costs borne by wholesalers and passed on to pharmacies as well as pharmacy profit. Average sales price would be defined by law and subject to Federal audit.

The Honorable John D. Rockefeller IV

Question 1:
Last week, the CMS Office of the Actuary (OACT) released data showing that the 10-year budget estimate for the Medicare law is $1.2 trillion when including premiums and "clawback" payments from the states. Without the premiums and payments from the states, the estimate is around $913 billion. However, in recent press reports, the Administration has cited a number closer to $720 billion, which allegedly is the net cost after subtracting the federal government's match for dual-eligible prescription drug costs that would have occurred in the absence of the Medicare law.

Please provide the Committee a detailed analysis, in writing, of OACT's assumptions regarding this change in the baseline. Specifically, I would like OACT's assumptions regarding the number of duals in each state, the cost for duals in each state, and the federal Medicaid match rate for the duals in each state for each year of the budget window. There is no other source for knowing what the federal government would have spent on prescription drug costs for duals in the absence of the Medicare law. The Congressional Budget Office (CBO) includes estimated savings to the federal government's share of Medicaid spending on duals in its overall baseline and no longer separately identifies spending that would have occurred absent the Medicare law.

Answer:
The CMS' estimates of the cost to the Federal government for the Medicare Prescription Drug program have remained virtually unchanged since the program was enacted. The Medicare actuaries originally projected that the benefit would have a net cost to the federal government of about $511 billion over the period 2004-13. Their current projections are now about $518 billion for the same period. The estimates in the President's budget now include two additional years of drug coverage, from 2006 through 2015. With more beneficiaries using more drugs in these years, the net cost is $724 billion. The actuaries' updated estimates for individual years are not significantly different from their original estimates.

Medicare will implement the drug benefit to provide access to up-to-date, medically necessary drugs at the lowest possible cost. The lower drug prices through price negotiation by drug plans, combined with other effective steps to manage drug costs, will lead to an estimated savings of 25 percent of drug costs compared to retail price levels - allowing beneficiaries to get much better access to medicines while still reducing overall drug spending by seniors. Analysis by both CBO and Medicare has concluded that the steps being used to implement the drug benefit lead to substantial cost savings – both CBO and the CMS actuaries have estimated that a centralized drug benefit, with government price negotiation, would not yield lower drug costs compared to current law. Moreover, government controls could restrict access to needed medicines.

Medicare is also providing new access to coverage that provides coordinated care, helping beneficiaries use medicines more effectively to prevent hospitalizations and other costly medical complications. In addition, Medicare is implementing many other provisions of the Medicare law like competitive bidding for services, lower payments for drugs, and an income-related Part B premium. All of these steps provide a stronger foundation to keep Medicare sustainable.

Question 2:
The Administration has argued that the increase in the Medicare cost estimate is primarily because 2006 is the first year that a 10-year projection includes all ten years of a benefit (2006-2015). However, there

are some very interesting changes in enrollment assumptions that have occurred since OACT's Mid-Session Review last June that I am hoping you will be able to shed some light on:

a. The CMS Issue Paper #5 on retiree coverage indicates that 9.8 million Medicare beneficiaries will receive drug coverage from an employer that is eligible for the subsidy. However, in Table D1 of the estimates that OACT released last week, only 7.6 million beneficiaries are estimated to receive coverage from an employer eligible for the subsidy in 2006. What is the reason for this discrepancy?

b. The trend line for retiree coverage from employers eligible for the subsidy goes down over the 10-year budget window 2004-2015, from 7.6 million in FY2006 to 4.1 million in FY2015. However, OACT's Mid-Session Review estimates from June show the same trend line going up, from 5.4 million beneficiaries in FY2006 to 6.5 million beneficiaries in FY2014. What assumption differences led to such a dramatic change in the trend line? Why is participation in the employer subsidy decreasing instead of increasing over time?

c. The OACT cost estimate of the employer subsidy from FY2004-FY2014 is now $42.5 billion when it was $47.3 billion in the Mid-Session Review. What assumption differences led to a decrease in the cost of the retiree subsidy? What are the particular assumptions about employer participation?

d. The new OACT estimates indicate that total enrollment in Part D is lower than previously estimated in the Mid-Session Review. There are lower enrollees by the end of the 10-year budget window than previously estimated, even while Part D costs are increasing substantially over the same period. What are OACT's new assumptions about beneficiary participation in Part D? Why are the enrollment estimates less than they were in June 2004?

Answer:
The CMS Office of the Actuary periodically updates their projections based on internal and external technical review and to take advantage of the most recent available data. The actuaries' year-to-year cost projections contained in the President's FY '06 budget remained very close to the cost projections prepared for the passage of the Medicare Modernization Act. The reason the federal cost numbers looked higher on their face was the fact that the budget window had moved forward two years – dropping 2004 and 2005, which were pre-implementation years containing no drug benefit spending, and adding 2014 and 2015, which will be two full benefit years trended forward for inflation and enrollment growth. Comparing the two estimates for the same years reveals that the new year-to-year estimates are within about 1 percent of the old estimates. Any differences stem from small technical adjustments to the estimation methods and the incorporation of newer and more complete data on prescription drug spending. We would be happy to arrange a briefing to provide more detail on the retiree drug subsidy estimates.

Question 3:
The President's FY2006 Budget proposes to extend the BBA 1997 hospital transfer provision to all DRGs, which would reduce payments to hospitals and reportedly save $740 million in FY2006 and $4.7 billion over five years. Please provide the Committee a state-by-state analysis, in writing, of the impact of this proposed change on hospitals (i.e. how much would hospitals in each state lose under this proposal).

Answer:
Expanding the post-acute transfer policy will reduce incentives to discharge patients prematurely to a post-acute care setting. The goal of the post-acute care transfer policy is to avoid duplicate payments for short-stay cases when the majority of the medical care is given at a post-acute care facility.

In the FY 2006 hospital inpatient prospective payment system (PPS) proposed rule, we proposed new criteria that expand the number of Diagnosis Related Groups (DRGs) subject to the post-acute care policy from the 30 to 223 (or slightly fewer than half of all DRGs). Consistent with the statute, the proposed new criteria are designed to capture those DRGs that include a high volume of discharges to post-acute care and a disproportionate use of post-acute care services.

It is also important to note that the relative weight (an important factor in determining payment) for a DRG under the hospital inpatient PPS is based on the average charge for all cases in the DRG. By reducing the influence that short-stay cases have on this calculation, the relative weight of the DRG may actually increase resulting in higher payments for patients that stay in the hospital for longer periods of time. In this way, the post-acute care transfer policy works to better target Medicare's payment based on the resource costs hospitals incur treating patients.

To address your concern regarding the impact of the post-acute transfer policy, I have attached the impact table from the FY2006 hospital inpatient PPS proposed rule (it can also be found on page 23657 of the May 4, 2005 Federal Register). This table shows the effect of the proposed policy on hospitals as broken down by size and geographic location.

Question 4:
Special efforts will be necessary in order to assist patients in long term care settings, other dual eligibles and beneficiaries with cognitive impairments with their transition to Medicare Part D coverage. These vulnerable patients have more complex medication regimens and will require focused resources to accomplish the transition. How will you ensure adequate resources are available through CMS and other agencies within the Department that have relevant expertise, such as SAMHSA, to address this critical need?

Answer:
CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006. This is critically important, especially for beneficiaries who live in long term care settings, and beneficiaries who take a number of prescriptions to manage their one or more chronic conditions.

As required under Section 107 (b) of the MMA, CMS undertook a study of the current standards of practice for pharmacy services provided to patients in nursing facilities. This effort included a thorough review of current standards of practice in long-term care pharmacies by collecting primary data and scanning existing information sources, developing a set of options for ways in which the long-term care pharmacy system can be smoothly and effectively integrated into Part D, and conducting a critical analysis of the relative pros and cons of each option. The resultant "Long-Term Care Pharmacy Primer" was released in December 2004 in advance of issuance of the Final Rule and guidance materials. This report may be found at http://www.cms.hhs.gov/researchers/reports/2004/LewinGroup.pdf.

CMS review of prescription drug plan formularies will ensure that plans offer a comprehensive array of drugs that reflects best practices in the pharmacy industry as well as current treatment standards. Our goal is to ensure beneficiaries receive clinically appropriate medications at the lowest possible cost. In reaching this goal, we also need to acknowledge the specific needs of individuals with certain medical conditions who are already stabilized on certain drug regimens (for example, enrollees with HIV/AIDS, mental illness, and those with other cognitive disorders).

CMS has developed a set of checks and oversight activities to ensure that prescription drug plans offer a comprehensive benefit that reflects best practices in the pharmacy industry as well as current treatment standards. As they develop their formularies, plans will need to recognize the special needs of particular types of beneficiaries, such as mental health patients, those with HIV/AIDS, those living in nursing homes, people with disabilities and other beneficiaries who are stabilized on certain drug regimens. We will review these formularies and benefit structures to: verify that plans offer multiple drugs in each class; verify that a plan's formulary was developed and reviewed by a pharmacy and therapeutics (P&T) committee consistent with widely used industry best practices, review the formulary classification formulary classification systems as well as the actual list of drugs included in the formulary; and ensure that benefit management tools are being applied in a clinically appropriate fashion.

To address the needs of individuals who are stabilized on certain drug regimens, Part D plans are required to establish an appropriate transition process for new enrollees who are transitioning to Part D from other prescription drug coverage, and whose current drug therapies may not be included in their Part D plan's formulary. This transition process will need to address the plan sponsor's method of educating both beneficiaries and providers to ensure a safe accommodation of an individual's medical needs with the plan's formulary. We believe some period of adjustment may be necessary to introduce the new formulary requirements, and set forth our expectations of what constitutes a reasonable transition timeframe.

CMS has also developed appeals procedures that ensure enrollees quickly receive decisions regarding medically necessary medications. For example, if an enrollee requests a coverage determination or exception, the plan must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination.

Additionally, CMS has established specific protections for beneficiaries who live in long-term care facilities and get their prescriptions from long-term care pharmacies. As a condition of providing the new benefit, every plan must provide coverage to all its enrollees who live in any nursing home in its region. To help facilitate the transition, the Medicare prescription drug plans will be notified as to which of their enrollees live in a long-term care setting. This will help the plans and the facilities prepare for any potential changes to a beneficiary's drug regimen. Because a large number of long-term care residents are full-benefit dual eligibles, it is important for the transition process that plans employ to account for any issues associated with filling the first prescription of a non-formulary drug. Medicare prescription drug plans will need to ensure that long-term care pharmacies in their network work with long-term care facilities before enrollment begins to ensure a smooth transition.

Question 5:
You are also proposing to limit "questionable asset transfers as part of an effort to promote personal responsibility and planning for long-term care expenses" (p. 144). Do you have a specific policy in mind for accomplishing this objective?

Answer:
Current law requires individuals applying for Medicaid long-term care services to divest all but a minimum level of assets before becoming eligible. If applicants transfer assets at below market value to avoid these requirements, Medicaid rules hold them subject to delays in eligibility. Despite these sanctions, creative estate planning often allows individuals to garner Medicaid eligibility status without divesting their assets. The President's FY 2006 budget proposes to curtail this practice by tightening existing rules regarding transfers of assets.

Question 6:
The President's FY2006 Budget proposes "to provide States with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government. This proposal would build on the success of SCHIP to provide acute care for children and families, as well as current efforts to reduce the number of uninsured individuals" (p. 137). Can you provide more details about this proposal? Are you proposing to cap federal Medicaid payments to states on a per capita, allotment, or other basis for some or all of the populations Medicaid covers?

Answer:
The Administration, Congress, and Medicaid stakeholders need to discuss the Medicaid program both in terms of how it is designed to deliver health insurance coverage and long-term care services, and how it is financed. Service delivery for individuals who rely on Medicaid can be improved, and the program can be expanded to provide a basic package of health services for more of our low-income citizens. More importantly, reform should be designed to give states the tools they need to bring Medicaid into the 21st century. Medicaid's mission has changed and expanded, but its 1960s rules limit its ability to offer choices that people want and need.

We can improve coverage of optional populations. Whether it's a lady in a nursing home or a boy in a wheelchair, we have a very special obligation to our neighbors who are elderly, low-income, or have disabilities. We meet that obligation by providing a comprehensive package of benefits and services. Mandatory populations need the help. They must receive the help. The optional populations, on the other hand, may not need such a comprehensive solution. Many of them are healthy people who just need help paying for health insurance. We've already proven a way to provide that help. The State Children's Health Insurance Program (SCHIP) has allowed 6.1 million children in low-income families who don't qualify for Medicaid to have health insurance. One of the key reasons SCHIP has been such a resounding success is that it allows states to ask the question, "What is quality basic health coverage?" And each state can choose from five answers: the health benefits state employees get, the benefits federal employees get, the best private health plan in their state, Medicaid, or some hybrid of private and government plans. Fewer than 20 states and territories chose the straight Medicaid option. A majority chose some other combination. It costs states less, on average, to provide health insurance than to provide comprehensive care. SCHIP is a proven model on which to base a discussion of how to best structure coverage for optional populations.

We are not proposing a block grant or per capita cap system for Medicaid.

I look forward to working with the Congress on modernizing the Medicaid program.

Question 7:
How does the Administration propose to increase coverage among low-income individuals and families "without creating additional costs for the Federal Government?" Does this mean there will be caps or limits on the amount of federal funds states have to serve these populations in order to maintain budget neutrality?

Answer:
We are not proposing a block grant or per capita cap system for Medicaid. The Administration, Congress, states and other stakeholders need to discuss the Medicaid program both in terms of how it is designed to deliver health insurance coverage and long-term care services, and how it is financed. Service delivery for individuals who rely on Medicaid can be improved, and we can give the states the flexibility they need to provide a basic package of health services for more of our low-income citizens, including a greater use of private coverage options. A truly modernized Medicaid program should give states the tools they need to bring this important program into the 21st century. Medicaid's mission has changed and expanded, but its 1960s rules limit states' ability to offer choices that people want and need. In short, the program has not kept pace with the people it serves.

I look forward to working with the Congress on modernizing the Medicaid program.

Question 8:
If the Administration believes that "increases in coverage among low-income individuals and families" can be achieved without "creating additional costs for the Federal Government" or the states, what does the Administration mean by "coverage?" Does it mean, as under Utah's HIFA waiver, coverage for primary care services only, with no coverage for hospitalization or specialty care?

Answer:
The Administration, Congress, and Medicaid stakeholders need to discuss the Medicaid program both in terms of how it is designed to deliver health insurance coverage and long-term care services, and how it is financed. Service delivery for individuals who rely on Medicaid can be improved, and the program can be expanded to provide a basic package of health services for more of our low-income citizens. More importantly, reform should be designed to give states the tools they need to bring Medicaid into the 21st century. Medicaid's mission has changed and expanded, but its 1960s rules limit its ability to offer choices that people want and need.

We can improve coverage of optional populations. Whether it's a lady in a nursing home or a boy in a wheelchair, we have a very special obligation to our neighbors who are elderly, low-income, or have disabilities. We meet that obligation by providing a comprehensive package of benefits and services. Mandatory populations need the help. They must receive the help. The optional populations, on the other hand, may not need such a comprehensive solution. Many of them are healthy people who just need help paying for health insurance. We've already proven a way to provide that help. The State Children's Health Insurance Program (SCHIP) has allowed 6.1 million children in low-income families who don't qualify for Medicaid to have health insurance. One of the key reasons SCHIP has been such a resounding success is that it allows states to ask the question, "What is quality basic health coverage?" And each state can choose from five answers: the health benefits state employees get, the benefits federal employees get, the best private health plan in their state, Medicaid, or some hybrid of private and

government plans. Fewer than 20 states and territories chose the straight Medicaid option. A majority chose some other combination. It costs states less, on average, to provide health insurance than to provide comprehensive care. SCHIP is a proven model on which to base a discussion of how to best structure coverage for optional populations.

With regard to the Utah waiver, the waiver expansion program provided care to individuals who would not otherwise have had access. The design of the waiver focused on preventive and basic care for the expansion population. Nonetheless, progress has also been made to expand access to specialists as well. The Utah Department of Health reports that:

- Almost 600 Primary Care Network (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 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.

Question 9:
The President's Budget also proposes to replace Medicaid best price with a budget neutral flat rebate. What is the policy rationale for eliminating best price? How would the proposed flat rebate work? What would make the flat rebate budget neutral over the 10-year budget window? Would generic drugs be included in this flat rebate? If so, what impact would such a flat rebate have on generic drug incentives?

Answer:
The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called lowest private market price or best price. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. The Administration proposes replacing best price with a budget neutral flat rebate. Eliminating best price and revising the rebate percentage to offset the cost would allow private purchasers to negotiate lower drug prices. This proposal will have no effect on the Medicaid budget.

Question 10:
The President's Budget includes significant Medicaid provider cuts for the stated purpose of reining in Medicaid fraud and abuse. Please identify and define specific forms of impermissible financial gamesmanship by the states which would warrant such cuts. What states are using these inappropriate financing mechanisms to defraud Medicaid?

Answer:
Medicaid is a partnership between the federal government and the states. Over the last two decades, states have developed innovative ways of enhancing federal matching dollars.

CMS is responsible for strengthening financial oversight and ensuring payment accuracy and fiscal integrity in the Medicaid program. The statute requires that federal matching funds must be a match for real Medicaid expenditures for Medicaid beneficiaries. At the federal level, our primary role is to exercise proper oversight and review of state financial practices and to provide guidance and support for states' efforts to ensure program and fiscal integrity. While we have made substantial progress in helping states identify and reduce improper payment mechanisms, we are also strengthening Medicaid federal financial management activities.

Since August 2003, as part of the review process for state requests for changes in payment methodologies through State Plan Amendments (SPAs), CMS has been examining information from states regarding detail on how states are financing their share of Medicaid program costs. This examination is applied consistently and equally to all states under the SPA review process. New SPA proposals will not be approved until CMS has determined that the state is securing appropriate non-federal funding to finance its share of its Medicaid program or has agreed to terminate financing practices that do not appear consistent with the statutory federal-state financial partnership.

During that SPA review process, CMS has discovered that some states utilize financing techniques that do not comport with the statutory requirements that establish the federal-state partnership. Specifically, CMS has discovered that several states make claims for federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the "guise" of intergovernmental transfers (IGTs), state and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the federal taxpayer.

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 (even though 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 actual Medicaid program costs than the federal statute authorizes.

Through our state plan amendment reviews, we have determined that in some instances states are using Federal Medicaid dollars to supplant the required state share for their Medicaid programs, and in other instances are re-directing the Federal Medicaid dollars to otherwise pay for care associated with non-Medicaid uninsured populations. Once the effective Federal share (FMAP) is raised through various financing and transfer mechanisms, however, it becomes impossible to determine what items and programs are now being financed with Medicaid dollars. Federal dollars are supplanting state dollars and the Medicaid program is unquestionably paying for things that it should not be paying for. A Federal dollar "recycled" to supplant the non-Federal Medicaid dollar means that the non-Federal dollar is available for spending for other state purposes (including traditional state responsibilities such as roads, bridges, foster care or schools).

While some have argued that there are significant benefits from this "redirected" spending, particularly spending on behalf of the uninsured population, it is important to note that we are working hard to help

the states find creative ways to meet budgetary constraints and help the uninsured while still contributing the appropriate non-Federal share of Medicaid expenditures, as defined by the state-Federal partnership articulated in the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS) has made great progress in both identifying states' inappropriate recycling arrangements and ending them. To date, CMS has reviewed over 750 State Plan Amendments (SPAs). Based on CMS' reviews, 23 states have agreed to revise their intergovernmental transfer (IGT) mechanisms by removing recycling arrangements. This is an ongoing review process; as states submit new SPAs CMS will continue to review them to ensure they include appropriate financing mechanisms. The attached chart provides a list of states that use IGTs appropriately as well as a list of states CMS believes may be using inappropriate recycling arrangements.

Summary Of State Use Of IGTs And Recycling

State	(1) States that Do Not Use IGTs	(2) States that Use IGTs Appropriately	(3) States that have Revised Existing IGTs by Removing Recycling	(4) CMS Identifies Potential Recycling-States May Disagree	(5) Unknown-SPAs Pending Review	(6) No SPAs Submitted
Alabama			X(IH/NF/HHA) **			
Alaska	X (OP)			X (IH/NF)		
Arizona*					X (OP)	
Arkansas		X (PHYS)	X (IH/NF)		X (OP/PHYS)	
California	X (NF)	X(OP)		X (IH)		
Colorado	X (IH/NF/PHYS)					
Connecticut	X (IH/NF)					
Delaware						X
DC						X
Florida		X (IH/OP/NF/PHYS)				
Georgia			X (IH/NF)**			
Hawaii	X (IH/NF)					
Idaho	X (NF)	X(IH)***				
Illinois				X (IH/NF/OP)		
Indiana		X (IH/PHYS/OP/TRANS)				
Iowa				X (IH/NF/PHYS)		
Kansas			X (IH/NF)			
Kentucky	X (OP)		X (IH/NF)		X (SBS)	
Louisiana	X (DSH)		X (IH/OP/NF)			
Maine	X (NF/OP)	X (IH)				
Maryland	X (IH/NF/PHYS)					
Massachusetts			X (IH/OH/NF)			
Michigan		X(PHYS)	X (IH/NF)			
Minnesota			X (IH - GME)	X (IH/NF)		
Mississippi		X(NF)		X (IH)		
Missouri	X (IH)	X (PHYS)	X (NF)		X (OP)	
Montana		X (IH/TRANS)	X (NF)			
Nebraska	X (IH)		X(NF)			
Nevada	X(NF)	X (IH/CLINIC)			X (PROF)	
New Hampshire	X (IH)		X (NF)			
New Jersey			X(NF)**			
New Mexico						X
New York		X (CLINIC)	X (IH/DSH/OP/NF)			
N. Carolina	X (PHYS)			X (IH/OP)		
N. Dakota	X(IH)			X (NF)		
Ohio	X (NF)	X (IH)				
Oklahoma	X (NF)	X (PHYS)	X (IH/OP)			
Oregon		X (IH)	X (NF)		X(SBS)	
Pennsylvania	X (IH)		X(NF)			
Rhode Island	X (IH/NF)					
S. Carolina		X (OP)	X (IH/NF)		X (OLP)	
S. Dakota	X (IH)		X(NF)			
Tennessee				X (IH/NF)		
Texas	X (NF)	X (IH/OP)			X (OP/PHYS)	
Utah		X (IH/NF/PHYS)				
Vermont	X (IH/NF)					
Virginia			X (IH/NF)	X (OP)		
Washington			X(IH/NF)			
West Virginia		X (NF/IH/OP)				
Wisconsin		X (IH)	X(NF)			
Wyoming		X (IH/OP)				
Total States	23	21	23	10	8	3
	*Has not submitted any IH/NF SPAs	*** Final documentation of procedures pending	** Final SPAs to be submitted/approved			

Key
- NF - Nursing Facility Services
- IH - Inpatient Hospital Services
- DSH- Disproportionate Share Hospital
- OP - Outpatient Hospital Services
- SBS - School Based Services
- GME - Graduate Medical Education
- Trans - Transportation
- Clinic - Clinic Services
- Prof - Professional Services
- Phys - Physician Services
- OLP- Other Licensed Practitioners
- HHA- Home Health Agency

Question 11:
Another component of the President's Budget is a reduction in the Medicaid reimbursement rate for targeted case management (TCM) services to 50% for all states. This proposal would have a disproportionate impact on poorer states, like West Virginia, that have a higher FMAP. What is the policy rationale for this proposal? Is their specific evidence that suggests states are using expanded definitions of allowable services to shift costs onto Medicaid that are the obligation of other programs? If so, what states have had inappropriate payments for TCM services during the last four years and what are their current matching rates?

Answer:
Case management activities are a critical part of carrying out foster care, the Individual with Disabilities Education Act (IDEA) and criminal justice programs. There is evidence to indicate that states have attempted to shift costs associated with other social service programs to Medicaid. There are instances where the Medicaid program is being charged improperly for case management services when another program should maintain responsibility for payment.

Under the proposal, the match rate for case management will be the same as it is for an administrative activity. It does not eliminate federal financial participation (FFP) for case management services, nor does it affect Medicaid eligibility for those services or any other Medicaid services. In addition, the proposal does not affect the amount of reimbursement that states will receive for Medicaid services to which an individual may be referred by a case manager.

Since 2002, 9 State Plan Amendments (Iowa, Maryland, Illinois, New Jersey, South Dakota, Rhode Island, Missouri, Florida and California) have been disapproved because they provided for Medicaid coverage of non-Medicaid activities, (TCM for children in foster care, juvenile justice, or IDEA). Six State Plan Amendments (SPAs) were withdrawn by the states when disapproval was imminent. Two states elected not to submit SPAs after discussion with CMS.

Question 12:
Aside from the impact that the proposed TCM funding reduction would have on low-income states like West Virginia, I am genuinely surprised that the Administration has included this item in its budget submission. It is my understanding that targeted case management is primarily used in many states to coordinate required care for people with disabilities, who often have very complex medical needs. For example, a case manager will help a child with cerebral palsy gain access to occupational therapy, physical therapy and speech-language services. Targeted case management is also employed to help people with severe mental illnesses obtain access to housing, rehabilitation, and social support services.

Given that the President's budget also includes the New Freedom Initiative, which is designed to enhance community-based options, I am wondering why CMS would include a proposal that makes it harder for people with disabilities to live in the community. Wouldn't you agree that that this proposed funding cut will seriously impact care coordination for some of our most vulnerable citizens?

Answer:
The proposal supports the coordination of care through case management activities. Case management services will be reimbursed at the same level as an administrative activity and the proposal does not affect the amount of reimbursement that states will receive for Medicaid services to which an individual may be referred by a case manager.

Case management activities are a critical part of carrying out foster care, the Individual with Disabilities Education Act (IDEA) and criminal justice programs. There is evidence to indicate that states have attempted to shift costs associated with other social service programs to Medicaid. There are instances where the Medicaid program is being charged improperly for case management services when another program should maintain responsibility for payment.

Under the proposal, the match rate for case management will be the same as an administrative service. It does not eliminate federal financial participation (FFP) for case management services, nor does it affect Medicaid eligibility for those services or any other Medicaid services.

Question 13:
The Budget (p. 144) also proposes $6 billion in federal savings by establishing fixed "administrative claim allotments." These "administrative claim allotments" appear to be a block grant to states, in this case for administrative costs. Is this in fact a block grant?

Answer:
The President's FY 2006 Budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming.

Question 14:
Which of the following administrative costs will be subject to fixed allotments under the President's proposal:

Additional administrative costs imposed by MMA for implementation of Part D?
Outreach and enrollment?
Improvements to program integrity efforts?
Improvements in computer systems to improve quality of care, better facilitate electronic medical records, and improve program management?
Medicaid fraud control units?
Medicaid management information systems (MMIS)?
Survey and certification of nursing homes and ICFs/MR?
Immigration status verification?
External quality review of managed care organizations?
Quality improvement organizations?
Claims processing?
Managed care contracting?
Drug utilization review?
Disease management?

Answer:
The President's FY 2006 Budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming.

Question 15:
The Administration recently proposed regulations to require states to measure improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) at an estimated cost of more $1 million per state each year. How do you reconcile this new rule with capping administrative funding?

Answer:
In 2004, we published a proposed rule in the *Federal Register*, which would require State agencies to estimate improper payments in the Medicaid program and SCHIP program. The Administration agrees with Congress that the executive agencies must uphold their fiduciary obligations to the federal taxpayer to ensure that the payments are properly made when Federal funding is involved. The 2004 proposed regulation was necessitated by legislation Congress enacted, the Improper Payments Information Act of 2002. This statute requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report those estimates to the Congress and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments.

The expected results of this proposed rule would be for States to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities that can be addressed by the States through actions taken to reduce the rate of improper payments and produce a corresponding increase in program savings at both the State and Federal levels.

The President's FY 2006 Budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming.

Question 16:
What will be the formula used for allotting federal matching funds for administrative costs among the states? What base year will the formula use?

Answer:
The President's FY 2006 Budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming.

Question 17:
States are already projected to run short of the SCHIP funds required to serve children currently enrolled in their programs. Last year, I joined Senators Chafee, Kennedy and Snowe in introducing legislation to alleviate these funding shortfalls. However, instead of redistributing the $1 billion in federal SCHIP funds that reverted to the Treasury at the end of the FY2004, the President's FY2006 Budget proposes to reauthorize SCHIP early, without any increase in federal CHIP funding. Don't you agree that additional funding is necessary to maintain coverage for children already enrolled in the program?

Answer:
The President's FY 2006 budget proposes to reauthorize SCHIP early for ten years at the current law levels and $5 billion per year in the out years. In addition, this proposal seeks to better target SCHIP funds in a more timely manner. The proposal accomplishes this by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year.

There are sufficient funds in the SCHIP program to meet current state needs, as well as to cover additional children that would be enrolled as a result of the comprehensive outreach efforts that President Bush has proposed through the Cover the Kids campaign. States have submitted SCHIP estimates to us for FY 2005 that indicate that they only anticipate spending $5.3 billion of their available allotments. Once I have completed the redistribution of FY 2002 funds to meet the needs of the states

that may otherwise have experienced shortfalls in FY 2005, there will be more than enough money to meet the needs of all states for their current enrollees, as well as to cover new children who we want to find through outreach efforts.

Question 18:
The Administration proposes a "national outreach campaign," including $1 billion in grants over two years "to enroll as many Medicaid- and SCHIP-eligible children as possible." Are you proposing that the grant funds be discretionary or mandatory spending?

Answer:
A national outreach campaign would be established that would provide $1 billion over two years in outreach grants to states, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. The grants to states will not come out of their SCHIP allotments and will not be subject to the 10 percent cap on administrative expenditures.

The proposal is included in the State Grants and Demonstration account as mandatory spending.

Question 19:
How "national" do you expect this outreach initiative to be? How many states do you expect will apply for grant funds? How do you think states that are already struggling to cover kids under SCHIP will respond to such a campaign?

a. Do you expect states like Tennessee, which is planning to disenroll 323,000 adult beneficiaries, or Mississippi, which is planning to disenroll 50,000 elderly and disabled beneficiaries, to apply for these outreach grants?

b. Do you expect the 29 states with declining federal matching rates in FY 2006, including West Virginia, to apply for outreach grants and enroll more children?

c. Do you expect the 12 states that have shortfalls in CHIP funding in FY 2006 and the 18 states that have shortfalls in SCHIP funding in FY 2007 to apply for outreach grants and enroll more children?

d. You propose a total of $23 billion over 10 years in savings from four different restrictions on the use of IGTs and provider taxes. These proposals, if enacted, will require the affected states to find different sources of funds if they wish to maintain their current level of Medicaid spending. Do you expect that these affected states will apply for grants to enroll more children in their programs?

Answer:
The proposal is included in the State Grants and Demonstration account as mandatory spending.

- **How many children do you expect to enroll as a result of this national outreach initiative in each year of the 5-year period?**

Answer:
Estimates made by various organizations put the number of uninsured children at 9 million. It is expected that three quarters of those could be eligible for Medicaid or SCHIP. The innovative approaches included in the President's FY 2006 budget will work to reduce that number.

- **Your estimate for the total 10-year cost of this initiative is $11.3 billion, yet only $1 billion is grant funding. Of the remaining $10.3 billion, how much do you estimate is attributable to new Medicaid spending, and how much is attributable to new S-CHIP spending?**

Answer:
The President's FY 2006 Budget estimates that Medicaid costs would be $ 10.05 billion between FY 2006 and FY 2015 while SCHIP costs would be $267 million over the same period.

- **How much additional state-only dollars do you estimate states will spend to match your estimated $10.3 billion in federal spending? Where will these state-only dollars come from, given that you project program spending will increase about 7 percent per year without any additional enrollment?**

Answer:
We would estimate that the total state spending to match the $10.3 billion in new spending would be about $7.6 billion. While we understand the states' share represents new spending to cover previously uninsured children, given the improving fiscal condition of states and the long term benefits of investing in the health care and coverage of our children, we believe states will have the incentive to fund provide the necessary funds.

- **Page 138 of the President's FY 2006 budget indicates that, although the S-CHIP program does not expire until the end of FY 2007, the Administration this year "will seek authority to better target S-CHIP funds in a more timely manner." The Budget does not appear to provide any new federal funds for this authority. How will this new S-CHIP authority accommodate the Administration's predicted increase in enrollment resulting from the national outreach initiative?**

Answer:
The Administration proposes to reauthorize SCHIP early for ten years at the current law levels and $5 billion per year in the out years. In addition, this proposal seeks to better target SCHIP funds in a timelier manner. The proposal accomplishes this by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year. With this change we believe there will be sufficient funds to accommodate the additional enrollment in SCHIP resulting from the Cover the Kids initiative.

Question 20:
Will the outreach grant funds be available for states to distribute, or will they also be available directly to community-based groups that are not under state oversight?

Answer:
A national outreach campaign would be established to provide $1 billion over two years in outreach grants to states, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. The new initiative will use a portion of these funds for new outreach programs at the community level to rekindle efforts to find and enroll these uninsured children. These funds would go directly to schools, community organizations, and tribes. The initiative will also include funding for a Federal outreach campaign. Finally, the initiative will reward states that

are most successful in increasing enrollment by providing funding in the form of performance-based grants to states that increase health insurance coverage to children in families with income less than 200 percent of the federal poverty level.

Question 21:
For grant funds available to the states, on what basis will they be allocated?

a. Will the states be required to match the federal grant funds with their own funds? If so, at what rate?

b. Will these grant funds count against a State's administrative claims allotment?

Answer:
A national outreach campaign would be established that would provide $1 billion over two years in outreach grants to states, schools, tribes and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP.

The President's proposal to establish Medicaid and SCHIP outreach grants is not part the proposal to establish an administrative claims allotment nor would these funds be part of the current law SCHIP ten percent administrative allotment.

Question 22:
How many children do you expect to enroll as a result of this national outreach initiative in each year of the 5-year budget period?

Answer:
Estimates made by various organizations put the number of uninsured children at 9 million. It is expected that three quarters of those could be eligible for Medicaid or SCHIP. The innovative approaches included in the President's FY 2006 budget will work to reduce that number.

Question 23:
The President's Budget proposal includes a total of $11.3 billion for this outreach campaign, yet only $1 billion is grant funding. Of the remaining $10.3 billion, how much do you estimate is attributable to new Medicaid spending, and how much is attributable to new SCHIP spending?

Answer:
The President's FY 2006 Budget estimates that Medicaid costs would be $ 10.05 billion between FY 2006 and FY 2015 while SCHIP costs would be $267 million over the same period.

Question 24:
How much additional state-only dollars do you estimate states will spend to match your estimated $10.3 billion in federal spending? Where will these state-only dollars come from, given that you project program spending will increase about 7 percent per year without any additional enrollment?

Answer:
We would estimate that the total state spending to match the $10.3 billion in new spending would be about $7.6 billion. While we understand the states' share represents new spending to cover previously uninsured children, given the improving fiscal condition of states and the long term benefits of investing in the health care and coverage of our children, we believe states will have the incentive to fund provide the necessary funds.

Question 25:
The Budget (p. 138) indicates that, although the SCHIP program does not expire until the end of FY 2007, the Administration this year "will seek authority to better target SCHIP funds in a more timely manner." Can you provide specific details about this new authority? Is this new authority a part of the larger reauthorization proposal or is it separate? How will this authority accommodate the Administration's predicted increase in enrollment resulting from the national outreach initiative?

Answer:
The Administration proposes to reauthorize SCHIP early for ten years at the current law levels and $5 billion per year in the out years. In addition, this proposal seeks to better target SCHIP funds in a more timely manner. The proposal accomplishes this by shortening the length of original availability of annual SCHIP allotments from three years to two years. Once the two-year period expires, the funds could then be redistributed to states facing shortfalls. Remaining funds would be redistributed to those that have expended all of their original allotment. The redistributed amount would then be available for an additional year. With this change we believe there will be sufficient funds to accommodate the additional enrollment in SCHIP resulting from the Cover the Kids initiative.

Question 26:
Please provide the most recent state-by-state data (January 2005) on SCHIP enrollment and spending. How have your FY2005, FY2006, and FY2007 federal shortfall state estimates changed based on this data?

Answer:
Attached are SCHIP state-by-state expenditures reported by the states through December 31, 2004.

- The table entitled "Total Expenditures Applied Against Allotments" includes the expenditures as applied to each FY SCHIP allotment.
- The table entitled "State Children's Health Insurance Program (SCHIP) Federal Expenditures: Medicaid Expansion and State Only Programs" includes expenditures as reported by fiscal year.
- The table entitled "SCHIP FY 2003 Allotments, Applied Expenditures, and Unexpended Balances" presents a summary of SCHIP allotments, expenditures and the balance of the allotments at 12/31/04.

Also attached is a chart with SCHIP enrollment information.

Based on our current analyses of spending and enrollment data (provided as requested), we estimate that there will be a Federal shortfall affecting several states in FY 2006, and additional Federal shortfall affecting more states in FY 2007. The Administration believes it important to note that globally, within the program as a whole, there are enough Federal dollars authorized to continue to operate SCHIP in the out years, but the current process for redistributing the dollars across states prevents the dollars from flowing fast enough to the states in which they are most needed. We expect that pursuing a longer-term "solution" to SCHIP will necessarily be part of the reauthorization discussions on SCHIP for FY 2007.

STATES	Expenditures Applied Against the FY 1998 Allotment	Expenditures Applied Against FFY 1998 Ret'd/Red'd	Expenditures Applied Against FY 1999 Allotment	Expenditures Applied Against FFY 1999 Ret'd/Red'd	Expenditures Applied Against FY 2000 Allotment	Expenditures Applied Against FFY 2000 Ret'd/Red'd	Expenditures Applied Against FY 2001 Allotment	Expenditures Applied Against FFY 2001 Ret'd/Red'd	Expenditures Applied Against FY 2002 Allotment	Expenditures Applied Against FFY 2002 Redistribution	Expenditures Applied Against FY 2003 Allotment	Expenditures Applied Against FY 2004 Allotment	Expenditures Applied Against FY 2005 Allotment	Total Expenditure Applied Against Allotments
	Total Expenditures Applied Against Allotments**													
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
ALABAMA	57,311,038	18,812,188	23,136,256	$25,174,684	28,818,937	$24,096,861	47,221,655	$11,044,689	$48,585,422	$0	30,097,591	0	0	314,999,321
ALASKA	5,889,296	15,008,551	6,656,760	$38,614,078	7,730,025	$18,827,483	8,987,100	$0	$6,968,138	$0	1,597,654	0	0	111,476,053
ARIZONA	38,242,369	50,733,462	0	$48,735,999	75,293,441	$27,459,818	124,519,004	$52,127,325	$87,166,211	$69,640,272	87,709,090	66,571,964	0	728,198,985
ARKANSAS	2,202,763	28,617,793	0	$10,990,464	0	$15,712,574	0	$15,640,854	$0	$0	0	0	0	83,064,448
CALIFORNIA	257,011,950	385,969,313	0	$356,616,040	23,061,375	$371,243,166	193,776,325	$255,576,301	$405,981,074	$0	130,482,229	0	0	2,379,719,772
COLORADO	23,942,735	11,526,664	9,416,342	$13,490,080	17,691,235	$14,599,500	25,998,147	$9,325,205	$28,302,704	$0	9,121,030	0	0	163,413,722
CONNECTICUT	25,062,575	6,391,454	6,788,232	$11,741,354	4,428,705	$17,399,284	0	$19,699,011	$0	$0	3,150,661	0	0	94,859,280
DELAWARE	2,289,855	3,722,312	0	$3,360,453	0	$4,518,130	0	$4,495,482	$0	$0	0	0	0	18,386,232
DISTRICT OF COLUMBIA	6,262,215	3,754,719	1,521,895	$4,400,963	1,968,733	$4,874,171	1,142,796	$5,304,374	$1,916,909	$0	1,487,494	0	0	31,734,080
FLORIDA	183,046,365	56,295,954	138,922,871	$54,508,840	215,487,253	$13,278,732	220,217,985	$40,758,936	$164,157,640	$0	171,990,713	0	0	1,258,665,218
GEORGIA	56,178,912	44,277,920	32,849,832	$38,244,656	67,836,544	$32,372,390	136,053,332	$50,080,828	$104,986,194	$21,582,616	98,976,597	0	0	680,188,521
HAWAII	420,296	6,505,707	0	$3,732,590	0	$5,016,468	0	$5,834,583	$4,398,741	$0	3,232,981	0	0	29,343,366
IDAHO	12,775,832	2,004,705	10,982,296	$2,021,801	12,328,159	$2,744,707	9,411,471	$5,651,819	$4,768,456	$0	3,940,069	0	0	70,629,064
ILLINOIS	53,472,202	44,598,686	0	$51,127,266	0	$68,740,615	0	$79,919,379	$127,220,093	$16,630,068	115,753,594	0	0	557,461,905
INDIANA	70,512,432	44,998,436	70,179,422	$106,303,421	50,187,036	$8,487,222	0	$30,011,896	$0	$0	3,206,929	0	0	380,896,494
IOWA	20,332,129	3,967,893	20,888,893	$4,787,171	23,937,736	$4,222,574	28,862,733	$2,138,741	$22,411,236	$4,570,803	17,843,987	0	0	159,553,686
KANSAS	21,561,892	5,873,585	18,735,496	$4,937,167	36,320,974	$21,481,440	29,337,719	$0	$21,978,619	$0	15,361,148	0	0	169,588,040
KENTUCKY	49,932,527	27,919,367	48,896,709	$80,661,516	56,025,996	$0	55,935,972	$0	$38,435,891	$0	18,293,723	0	0	376,895,699
LOUISIANA	35,655,148	42,677,548	0	$42,451,541	19,852,547	$35,739,091	42,625,806	$19,695,925	$57,691,885	$0	43,796,490	0	0	339,985,988
MAINE	12,466,977	4,531,728	12,428,004	$18,728,463	13,976,906	$9,665,648	13,444,691	$0	$9,994,090	$0	3,857,380	0	0	99,114,985
MARYLAND	61,627,358	44,666,800	61,338,309	$129,051,173	56,869,896	$123,597,951	51,422,315	$0	$33,927,307	$0	27,978,514	0	0	590,467,425
MASSACHUSETTS	42,836,231	38,714,812	42,633,928	$87,173,101	48,063,710	$21,828,451	55,879,946	$0	$45,318,812	$0	23,883,668	0	0	404,332,659
MICHIGAN	51,726,748	25,741,989	11,772,293	$33,280,202	6,268,727	$46,236,866	12,588,084	$53,442,252	$96,893,382	$0	53,702,837	0	0	393,674,064
MINNESOTA	15,221	18,329,150	0	$11,849,737	31,891,256	$16,265,510	37,042,610	$20,377,856	$30,041,680	$22,889,129	30,626,504	5,462,227	0	225,059,985
MISSISSIPPI	29,178,423	17,333,228	31,666,238	$10,098,560	58,036,228	$40,863,532	55,987,988	$33,325,491	$37,917,154	$12,628,034	37,672,898	0	0	364,708,772
MISSOURI	61,673,123	9,236,141	51,429,086	$61,787,084	1,278,214	$28,350,396	43,219,476	$11,120,449	$46,916,456	$382,182	43,424,901	0	0	347,816,488
MONTANA	4,887,358	4,425,898	9,429,823	$946,457	11,149,994	$1,011,564	11,031,111	$2,069,102	$10,932,606	$1,645,399	3,323,909	0	0	60,852,330
NEBRASKA	9,881,246	3,217,319	6,231,469	$3,580,293	8,218,671	$4,178,799	19,084,374	$5,985,864	$14,161,451	$0	15,414,316	8,567,651	0	98,510,453
NEVADA	13,063,864	11,200,783	3,260,643	$11,312,497	9,119,551	$10,703,421	11,595,386	$9,874,407	$10,758,689	$0	6,116,585	0	0	97,025,806
NEW HAMPSHIRE	2,539,250	5,760,258	0	$4,781,227	0	$5,131,930	0	$5,037,311	$0	$0	0	0	0	23,249,976
NEW JERSEY	70,008,328	11,889,456	68,000,320	$107,349,522	96,858,666	$165,576,828	98,823,044	$119,967,813	$69,478,513	$51,370,959	69,346,099	38,621,920	0	987,281,473
NEW MEXICO	4,210,228	37,950,579	0	$23,527,474	0	$0	0	$5,761,466	$0	$0	0	0	0	71,449,747
NEW YORK	255,626,409	434,890,258	264,419,158	$267,167,073	288,821,535	$0	322,075,819	$0	$233,993,235	$0	83,070,881	0	0	2,148,064,366
NORTH CAROLINA	79,508,462	20,902,191	79,132,966	$92,146,880	77,768,983	$5,721,110	103,718,942	$0	$81,129,294	$0	83,766,515	0	0	603,795,343
NORTH DAKOTA	1,859,325	2,054,654	425,096	$1,925,130	1,900,044	$1,877,920	3,222,774	$1,878,441	$5,181,951	$0	1,639,788	0	0	21,963,143
OHIO	97,579,565	11,724,916	88,430,119	$11,218,100	117,814,672	$6,921,613	132,497,208	$4,658,666	$108,125,285	$0	97,017,337	0	0	675,287,481
OKLAHOMA	51,257,243	22,243,583	3,659,648	$34,226,186	0	$38,382,447	0	$34,544,202	$7,463,767	$0	13,398,759	0	0	205,172,845
OREGON	20,147,896	12,253,831	2,530,232	$15,259,655	1,026,305	$21,434,786	0	$25,067,050	$0	$0	7,648,397	0	0	105,377,132
PENNSYLVANIA	117,456,520	5,589,664	96,243,040	$7,731,864	90,688,050	$15,187,237	106,117,421	$16,925,892	$101,803,820	$0	53,993,354	0	0	610,536,712
RHODE ISLAND	10,684,422	1,988,850	10,633,962	$20,381,216	9,570,566	$26,796,370	9,300,803	$18,838,144	$7,473,463	$0	7,318,673	7,379,968	9,130,682	138,745,139
SOUTH CAROLINA	63,557,819	3,008,671	63,267,863	$0	71,314,037	$0	44,893,470	$9,848,882	$40,906,230	$0	15,244,642	0	0	317,031,413
SOUTH DAKOTA	4,655,275	2,509,663	2,720,031	$2,423,813	6,233,781	$858,784	6,177,039	$3,287,188	$5,941,727	$1,357,169	3,290,288	0	0	41,434,558
TENNESSEE	41,705,133	15,769,222	0	$7,309,867	0	$0	0	$636,472	$0	$0	0	0	0	65,240,694
TEXAS	81,281,672	310,043,570	0	$234,226,764	255,443,877	$123,664,391	281,964,260	$85,283,482	$197,200,669	$0	69,002,438	0	0	1,638,129,930
UTAH	20,835,906	2,190,215	20,359,242	$1,579,489	24,258,592	$1,470,407	18,619,845	$5,782,278	$22,250,242	$0	5,274,430	0	0	122,638,646
VERMONT	1,965,112	1,020,827	1,319,003	$932,239	1,630,778	$1,169,057	1,915,842	$1,348,077	$1,898,563	$0	1,248,960	0	0	14,427,246
VIRGINIA	23,549,911	28,910,583	16,176	$28,498,854	11,234,390	$31,173,037	20,076,059	$27,706,115	$35,248,201	$0	18,122,484	0	0	224,539,757
WASHINGTON	664,279	29,744,956	0	$19,470,237	0	$14,710,508	0	$19,128,895	$0	$0	0	0	0	83,858,875
WEST VIRGINIA	10,771,106	8,289,642	13,807,433	$4,019,077	21,145,730	$18,804,528	21,144,989	$0	$16,650,270	$0	10,716,627	0	0	125,450,002
WISCONSIN	23,461,361	11,069,997	40,441,141	$38,613,982	48,591,653	$50,795,546	48,597,070	$21,115,514	$39,374,831	$0	43,824,782	0	0	368,906,136
WYOMING	1,040,982	4,309,111	0	$3,217,921	0	$3,534,375	0	$3,596,832	$544,451	$0	1,323,289	0	0	17,565,852
TOTAL STATES	2,190,754,204	1,967,681,418	1,385,985,395	2,204,389,150	1,997,872,104	1,531,327,881	2,455,291,354	1,153,111,388	2,439,507,276	202,496,630	1,575,288,894	126,603,750	9,130,682	19,239,110,126
COMMONWEALTHS AND TERRITORIES														
PUERTO RICO	9,835,550	19,568,283	39,101,750	$27,109,558	41,116,950	21,221,544	41,116,950	894,545	30,296,700	6,180,597	30,296,700	0	0	268,729,225
GUAM	375,812	747,114	1,494,083	$1,035,846	1,571,060	810,887	1,571,062	642,761	1,157,625	87,153	1,157,625	1,157,625	0	11,805,828
VIRGIN ISLANDS	279,175	565,148	1,109,875	$760,465	1,167,075	602,356	1,167,075	478	859,950	0	859,950	0	0	7,370,569
AMERICAN SAMOA	128,850	256,222	512,250	$355,147	538,650	278,011	538,650	220,377	395,900	80,970	395,900	395,900	510,300	4,610,127
NORTHERN MARIANA ISL.	118,113	234,870	469,562	$325,551	493,762	254,644	493,763	202,012	363,825	74,222	363,825	363,825	467,775	4,225,949
TOTAL COMM. & TERR.	10,737,500	21,371,637	42,687,500	29,595,585	44,887,500	23,167,624	44,887,500	1,960,177	33,075,000	6,419,242	33,075,000	1,918,350	978,075	294,740,890
NATIONAL TOTAL	2,201,491,704	1,989,003,255	1,428,372,895	2,233,984,735	2,042,759,604	1,554,495,505	2,500,178,854	1,155,071,565	2,472,582,276	208,915,872	1,608,363,894	128,522,100	10,108,757	19,533,851,016

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FY 2005 First Quarter Ever Enrolled Data by State – Total SCHIP

State and Program Type	Total Number of Children Ever Enrolled in the First Quarter		FY 2005 First Quarter Total
	Separate Child Health Program	Medicaid Expansion	
Alabama (S)	66,355	–	66,355
Alaska (M)	–	13,309	13,309
Arizona (S)	56,144	–	56,144
Arkansas (C)	961	0	961
California (C)	735,729	104,681	840,410
Colorado (S)	NR	–	NR
Connecticut (S)	15,949	–	15,949
Delaware (C)	6,104	70	6,174
District of Columbia (M)	–	4,405	4,405
Florida (C)	326,907	1,405	328,312
Georgia (S)	223,073	–	223,073
Hawaii (M)	–	14,840	14,840
Idaho (C)	1,090	12,763	13,853
Illinois (C)	99,997	67,360	167,357
Indiana (C)	21,406	55,003	76,409
Iowa (C)	20,709	11,764	32,473
Kansas (S)	36,710	–	36,710
Kentucky (C)	17,875	35,804	53,679
Louisiana (M)	–	114,135	114,135
Maine (C)	4,985	11,625	16,610
Maryland (C)	8,256	88,285	96,541
Massachusetts (C)	28,924	62,535	91,459
Michigan (C)	NR	NR	NR
Minnesota (C)	2,443	34	2,477
Mississippi (S)	72,705	–	72,705
Missouri (M)	–	96,536	96,536
Montana (S)	11,349	–	11,349
Nebraska (M)	–	27,903	27,903
Nevada (S)	28,665	–	28,665
New Hampshire (C)	7,912	337	8,249
New Jersey (C)	74,137	36,018	110,155
New Mexico (M)	–	13,178	13,178
New York (C)	401,313	109,606	510,919
North Carolina (S)	139,712	–	139,712
North Dakota (C)	2,529	1,462	3,991
Ohio (M)	–	153,530	153,530
Oklahoma (M)	–	68,698	68,698
Oregon (S)	30,174	–	30,174
Pennsylvania (S)	137,072	–	137,072
Rhode Island (C)	515	11,327	11,842
South Carolina (M)	–	55,134	55,134
South Dakota (C)	2,547	9,254	11,801
Tennessee (M)	–	–	–
Texas (S)	385,578	–	385,578
Utah (S)	26,714	–	26,714
Vermont (S)	NR	–	NR
Virginia (C)	46,440	33,123	79,563
Washington (S)	15,563	–	15,563
West Virginia (S)	26,527	–	26,527
Wisconsin (M)	–	37,515	37,515
Wyoming (S)	4,287	–	4,287
TOTALS	3,087,356	1,251,639	4,338,995

S – Separate child health programs. M – Medicaid expansion programs. C – Combination programs.
NR – Indicates that state has not reported data via the Statistical Enrollment Data System (SEDS).

Question 27:
The budget proposes to eliminate funding for the Rural Hospital Flexibility Grant Program, the Title VII Health Professions Program, and Area Health Education Centers – all vital programs to West Virginia. Can you explain the policy rationale for eliminating these critical programs?

Answer:
HHS administers over 200 health and social service programs providing resources to rural areas. The Medicare Modernization Act will increase rural area payments in excess of $20 billion dollars over the next 10 years and the Community Health Center budget for 2006 of $2 billion dollars includes a proposed increase of $304 million dollars. Approximately 50 percent of the community health centers are located in rural areas and the increases approved will be apportioned to rural areas in like manner. These health care reimbursement and service delivery programs are addressing the need to imbed increasing attention to rural health care within the fabric of our major ongoing programs even as we retire those planning programs that have largely served their purpose.

The primary objectives of several of the Rural Health programs were development-oriented and have met their original program goals. For example, the Rural Hospital Flexibility Grant program was intended to support States in determining if rural hospitals would benefit from conversion to Critical Access Hospitals (CAHs). The majority of CAH conversions have already occurred over the last several years of State activity in policy planning and CAH candidate identification. Similarly, the Rural Access to Emergency Devices Grants program investment over several years has largely met the need, while the FY 2006 request will allow targeted investments in the few remaining areas of need.

To continue a rural health focus in general, specific funding is maintained in the FY 2006 budget request for certain rural health research and telehealth activities as well as funding for State offices of rural health while we move toward more rural health funding in our core entitlement and service delivery grant programs.

The spending priority is on expanding direct services through the Health Centers Program, the National Health Service Corp Program, graduate medical education and training, Bioterrorism Training and Education curriculum development program, and nursing education and training programs.

The number of primary care physicians and physician assistants has grown over the past decade. Salaries and economic incentives for primary care providers have also increased. The GAO reported in 2003 that the U.S. physician population increased by 26 percent, twice the rate of growth of the total population between 1991 and 2001. Many of the health professions programs were created in response to an anticipated national shortage of physicians. While geographic disparities persist, growth was seen in historically high-supply metro areas and low-supply statewide non-metro areas.
There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefited from Title VII program's, including the AHEC program, long-

term training support in 1999 to 2001 did not practice in shortage areas. The GAO concluded in 1994 that evaluations have not linked the health professions programs to changes in supply, distribution, and minority representation of health professionals.

The AHEC Programs have been well received and it is anticipated that they will be supported by State and local resources.

The Honorable Charles E. Schumer

Question 1:
Recent press reports have brought a lot of attention to CMS's estimates of the cost of the Medicare drug benefit. Having looked at an apples-to-apples comparison, I understand that the new estimate is fairly close to the 2003 estimate, with a few very expensive years tacked on at the end. However, I also understand that the assumptions underlying the new estimate may have changed substantially since the first estimate was completed – including assumptions about enrollment and about employer participation in the program, with the trend in the take-up rate for the employer subsidy actually being reversed in the new estimates. If this is true, then the similarity in the numbers raises just as many red flags in my mind as the initial shock of the $1.2T number did. Can you please explain the changes in the assumptions underlying these two estimates and the justifications for these changes?

Answer:
The CMS Office of the Actuary periodically updates their projections based on internal and external technical review and to take advantage of the most recent available data. The actuaries' year-to-year cost projections contained in the President's FY 06 budget remained very close to the cost projections prepared for the passage of the Medicare Modernization Act. The reason the federal cost numbers looked higher on their face was the fact that the budget window had moved forward two years – dropping 2004 and 2005, which were pre-implementation years containing no drug benefit spending, and adding 2014 and 2015, which will be two full benefit years trended forward for inflation and enrollment growth. Comparing the two estimates for the same years reveals that the new year-to-year estimates are within about 1 percent of the old estimates. Any differences stem from small technical adjustments to the estimation methods and the incorporation of newer and more complete data on prescription drug spending.

Question 2:
As a member of the National Governor's Association, you signed off on an NGA-wide resolution opposing caps and cuts to the Medicaid program. As part of that resolution, you stated explicitly that states believe that Medicaid is chronically underfunded because the federal government is shifting long-term care and other costs to the governors and to state taxpayers.

In now proposing very significant cuts to the Medicaid program, how can you reconcile not addressing this cost-shifting burden and actually making it worse? Not only will these cuts directly affect the quality of services available to Medicaid beneficiaries, but, as a former governor, you know that the effect of further shifting costs to the states will only force states to continue to raise already skyrocketing property taxes.

In addition, it will put a greater strain on private health coverage, causing premiums to go up for those who have private coverage and even further threatening employer-based coverage, and it will severely threaten access to quality nursing home care for people of

all income levels. Given these potentially devastating effects on the system at large, how can you justify such cuts to the Medicaid program?

Answer:
Medicaid provides health insurance for more than 46 million Americans but states still complain about overly burdensome rules and regulations, and the state-Federal financing system remains prone to abuse. This past year, for the first time ever, states spent more on Medicaid than they spent on K-12 education. Over the next ten years, American taxpayers will spend nearly $5 trillion dollars on Medicaid in combined state and Federal spending. Over the past ten years, Medicaid spending doubled. At its current rate of growth (7.5%), the Federal share of Medicaid spending would double again in another ten years. The growth in Medicaid spending is unsustainable.

The President proposes to give states more flexibility in the Medicaid program in order to enable states to increase coverage using the same Federal dollars. The tools we have at our disposal today were not available when Medicaid was created. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. The Administration has begun and will continue a serious discussion with Governors and Congress to decide the best way to provide states the flexibility they need to better meet the health care needs of their citizens.

To accomplish these goals, I believe success in reforming the Medicaid program has three components.

First, we must keep faith with the commitment this nation has made to provide access to acute and long-term care services to people with low incomes, disabilities, the elderly, and children.

Second, we must create enough flexibility in Medicaid that states are able to continue serving optional groups and expand the number of people they serve.

Third, we must assure the financial sustainability of Medicaid by returning integrity to the funding partnership.
I also would like to suggest three changes to Medicaid to help us meet these goals and to make the program sustainable into the future.

We must find every inefficiency because waste means covering fewer people. By way of example, we must stop overpaying for prescription drugs. Pharmacies and Medicare buy drugs wholesale for a low price. But under Medicaid, state governments usually pay a much higher price. The law should be changed so that states pay the same low rate. This will save the federal government $15 billion over the next ten years. It will save state governments $11 billion.

Medicaid must not become an inheritance protection plan. Right now, many older Americans take advantage of Medicaid loopholes to become eligible for Medicaid by

giving away assets to their children through estate planning. There is a whole industry that actually helps people shift costs to the taxpayer. There are ways families can preserve assets without shifting the costs of long-term care to Medicaid. These loopholes should be closed and we should focus Medicaid's resources on helping those who really need it. Doing so will save $4.5 billion during the next decade.

We must have an uncomfortable, but necessary, conversation with our funding partners, the states. State officials have resorted to a variety of loopholes and accounting gimmicks that shift the costs they claim to pay to the taxpayers of other states. If we don't close these loopholes, we project that over the next ten years they will shift $40 billion through various means.

By accepting these challenges, we can ensure that seniors and people with disabilities get long-term care where they want it. The President's New Freedom Initiative points us in the right direction. Home care and community care can allow many Americans with disabilities to continue to live at home, where they can enjoy family, neighbors, and the comfort of familiar surroundings. Additionally, it frees up resources that can help other people.

We can expand access to more children. But the principles will be the same. We can provide access to more needy people by providing common sense flexibility. And the President proposes to spend $1 billion in outreach funds to find children currently eligible for Medicaid and SCHIP who are not enrolled, and over $10 billion to care for them.

Finally, we can improve coverage of optional populations. Whether it's a lady in a nursing home or a boy in a wheelchair, we have a very special obligation to our neighbors who are elderly, low-income, or have disabilities. We meet that obligation by providing a comprehensive package of benefits and services. Mandatory populations need the help. They must receive the help. The optional populations, on the other hand, may not need such a comprehensive solution. Many of them are healthy people who just need help paying for health insurance. We've already proven a way to provide that help. The State Children's Health Insurance Program (SCHIP) has allowed 6.1 million children in low-income families who don't qualify for Medicaid to have health insurance. One of the key reasons SCHIP has been such a resounding success is that it allows states to ask the question, "What is quality basic health coverage?" And each state can choose from five answers: the health benefits state employees get, the benefits federal employees get, the best private health plan in their state, Medicaid, or some hybrid of private and government plans. Fewer than 20 states and territories chose the straight Medicaid option. A majority chose some other combination. It costs states less, on average, to provide health insurance than to provide comprehensive care. SCHIP is a proven model on which to base a discussion of how to best structure coverage for optional populations.

Question 3:
I support policies that make the Medicaid program more efficient. The program is already more efficient than Medicare or private insurance, with per capita cost increases much higher in Medicare and the private sector than in the Medicaid program. However,

there are significant enrollment burdens and cost-shifting problems that are not addressed in this budget. Instead, the Administration has proposed taking steps to cut off certain legal financing options states have been using such as intergovernmental transfers. Many states, including New York, depend on these funding streams to provide quality services within the Medicaid program.

If the true goal is ensuring program integrity, why doesn't the Administration propose putting these savings back into Medicaid to help states run their programs? Wouldn't this be a more efficient way to ensure program integrity rather than pulling the rug out from under states?

Answer:
Medicaid is a partnership between the federal government and the states. Over the last two decades, states have developed innovative ways of enhancing federal matching dollars.

CMS is responsible for strengthening financial oversight and ensuring payment accuracy and fiscal integrity in the Medicaid program. The statute requires that federal matching funds must be a match for real Medicaid expenditures for Medicaid beneficiaries. At the federal level, our primary role is to exercise proper oversight and review of state financial practices and to provide guidance and support for states' efforts to ensure program and fiscal integrity. While we have made substantial progress in helping states identify and reduce improper payment mechanisms, we are also strengthening Medicaid federal financial management activities.

Since August 2003, as part of the review process for state requests for changes in payment methodologies through State Plan Amendments (SPAs), CMS has been examining information from states regarding detail on how states are financing their share of Medicaid program costs. This examination is applied consistently and equally to all states under the SPA review process. New SPA proposals will not be approved until CMS has determined that the state is securing appropriate non-federal funding to finance its share of its Medicaid program or has agreed to terminate financing practices that do not appear consistent with the statutory federal-state financial partnership.

During that SPA review process, CMS has discovered that some states utilize financing techniques that do not comport with the statutory requirements that establish the federal-state partnership. Specifically, CMS has discovered that several states make claims for federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the "guise" of intergovernmental transfers (IGTs), state and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the federal taxpayer. While it is completely legal for states to share costs with counties and other local government bodies to recoup Medicaid expenditures, IGTs are only supposed to help states provide the statutorily determined match rate for a state.

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 (even though 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 actual Medicaid program costs than the federal statute authorizes.

Through our state plan amendment reviews, we have determined that in some instances states are using Federal Medicaid dollars to supplant the required state share for their Medicaid programs, and in other instances are re-directing the Federal Medicaid dollars to otherwise pay for care associated with non-Medicaid uninsured populations. Once the effective Federal share (FMAP) is raised through various financing and transfer mechanisms, however, it becomes impossible to determine what items and programs are now being financed with Medicaid dollars. Federal dollars are supplanting state dollars and the Medicaid program is unquestionably paying for things that it should not be paying for. A Federal dollar "recycled" to supplant the non-Federal Medicaid dollar means that the non-Federal dollar is available for spending for other state purposes (including traditional state responsibilities such as roads, bridges, foster care or schools).

While some have argued that there are significant benefits from this "redirected" spending, particularly spending on behalf of the uninsured population, it is important to note that we are working hard to help the states find creative ways to meet budgetary constraints and help the uninsured while still contributing the appropriate non-Federal share of Medicaid expenditures, as defined by the state-Federal partnership articulated in the Social Security Act.

CMS remains committed, however, to working closely with states to develop and implement programs that use "real" dollars to pay for the costs of caring for the uninsured population. Since the beginning of this Administration, we have worked closely to develop demonstration programs that help states address the plight of uninsured Americans. Most recently, for example, we approved a demonstration in the Commonwealth of Massachusetts that permits disproportionate share hospital (DSH) payments to be re-directed to pay for the costs of care of the uninsured populations outside of the hospital setting. The State will also be permitted to use these "re-directed" DSH dollars to eventually purchase health insurance coverage for some of the uninsured population in the State. By fully embracing the Federal-state partnership, CMS and the Commonwealth were able to create a demonstration program which will help reduce the rate of uninsured in Massachusetts. Allowing the Commonwealth to invest up to 10 percent of the Safety Net Care Pool (SNCP) for infrastructure and capacity building will now enhance the community provider network by increasing access to quality health care.

We believe that making it easier for people to obtain affordable health care coverage is key to addressing the problem of the uninsured in this country. We are very interested in

working with states such as Massachusetts to find creative approaches using real state dollars matched with Federal dollars to make coverage more affordable for low-income Americans.

Question 4:
Given the Administration's efforts to find savings and ensure integrity in the Medicaid program, I am a little baffled by your proposal to do away with Medicaid's best price formula. At a time when we should be doing more to leverage the federal government's negotiating power within Medicare and Medicaid, this proposal would explicitly allow the Medicaid program to pay more for drugs than other purchasers. In addition, as I read the proposal, it would remove the penalties brand companies pay for increasing their drug prices faster than the rate of inflation, thereby potentially providing a huge windfall to the brand companies.

With this penalty gone and a flat rebate which no longer ties into what prices other purchasers are paying, what is to stop drug companies from hiking up their prices – exactly as they did prior to the Medicare drug discount cards – and causing Medicaid to pay even more for drugs over time? I am very skeptical that this proposal could be in any way budget neutral – how do you intend for it to be so? Furthermore, given the federal budget situation, wouldn't a more efficient approach be to actually save Medicaid money by better leveraging Medicaid's buying power to get lower prices on drugs rather than effectively gutting it?

Answer:
The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called lowest private market price or best price. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. The Administration proposes replacing best price with a budget neutral flat rebate. Eliminating best price and revising the rebate percentage to offset the cost would allow private purchasers to negotiate lower drug prices. This proposal will have no effect on the Medicaid budget.

Question 5:
If your goal is to ensure that entities participating in the Medicare program can get the best prices for drugs, then why isn't the solution to leverage Medicare's buying power by allowing the Secretary to negotiate directly on drugs, instead of instituting policies which would effectively remove Medicaid's market leverage?

Answer:
Under the Medicare Modernization Act, the new Medicare prescription drug benefit will be provided through private health insurance organizations. In general, health plans that can negotiate favorable retail drug price discounts and drug manufacturer rebates, and take other steps to manage utilization and costs effectively, will be able to offer lower premiums to beneficiaries. Prescription drug plans that are effective in these efforts can gain a competitive advantage over other plans. CMS actuaries have estimated that

Medicare prescription drug plans can initially achieve an average cost reduction of 15 percent (compared to retail-level, unmanaged prescription drug costs), with this reduction increasing to 25 percent over a 5-year period. The ultimate savings level of 25 percent has frequently been achieved in practice by pharmacy benefit managers on behalf of large drug insurance plans. These savings assumptions were reviewed in 2004 by an independent panel of expert health actuaries and economists. The panel found the assumptions to be reasonable and did not recommend any changes to them.

Under section 1860D-11(i) of the Social Security Act, the Secretary of Health and Human Services is prohibited from interfering in the drug price negotiations conducted by Medicare prescription drug plans with drug manufacturers and pharmacies. Similarly, the Secretary cannot establish a price structure for reimbursing covered Part D drugs. The question has arisen as to whether allowing such a role for the Secretary could produce greater cost reductions than the negotiations of individual Medicare prescription drug plans. These estimated cost reductions reflect the combined effect of retail price discounts, manufacturer rebates, and utilization-management programs.

CMS has not prepared a formal estimate of the impact of eliminating section 1860D-11(i), but the Agency's actuaries have informally considered the issue and have reached the following tentative conclusions:

• As noted above, Medicare prescription drug plans will have a strong incentive to negotiate effective price reductions. Pharmacy benefit managers have had substantial experience with such efforts and have demonstrated their effectiveness for many years.

• The Secretary's ability to achieve price reductions would depend on the Federal government's willingness to use its large-purchaser power in a forceful way. At one extreme, the Secretary could virtually dictate price levels to manufacturers and retail pharmacies. In theory, such a practice could result in very large discounts, well in excess of our expected levels under the MMA. In practice, however, it is not clear that manufacturers and pharmacies would be willing to sell prescription drugs at very low prices mandated in this fashion. Moreover, we do not believe that the current Administration or future ones would be willing and able to impose price concessions that significantly exceed those that can be achieved in a competitive market.

• Establishment of drug price levels for Medicare by the Federal government would eliminate the largest factor that prescription drug plans could otherwise use to compete against each other. This change would have implications for the degree of competition in the Medicare prescription drug plan market, by reducing the premium differentials among plans. Lower premium differentials would reduce beneficiaries' incentives to select a lower-cost drug plan.

• The past experience of Congress and the Medicare program in regulating drug prices has not been reassuring. A well-known example is the Part B covered drugs. Prior to the MMA, these drugs were paid at rates that, in many instances, were substantially greater than prevailing price levels. In considering these issues, we believe that direct price

negotiation by the Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces.

Question 6:
On the heels of reports about the cost of the Medicare drug benefit, taxpayer-supported drug purchases are getting even greater scrutiny, as they should. The last time you were here, I submitted a question asking about CMS's policy regarding the treatment of "authorized generics" – generic versions of drugs that are produced by a brand manufacturer on the same lines as the brand-labeled drugs.

In your response, you stated that CMS treats authorized generics as the same as the brand drug. However, I now understand that this policy only applies when CMS is deciding which rebate should be paid on the authorized generic version of the drug, and that it does not apply when CMS decides what rebate should be paid on the brand drug. Instead, CMS conveniently treats an authorized generic as different from the brand drug in the latter instance, which allows the brand company to escape reporting the price of the authorized generic when it reports its "best price" to the Medicaid program. In my view, the effect of this policy is to prevent Medicaid from getting the highest rebates on brand drugs allowed under the law. If the Administration really wants to close so-called "loopholes" in the Medicaid program, I would think this would be a good place to start.

First, what is the justification for the inconsistency in CMS policy here? And second, the President has proposed getting rid of Medicaid's best price system altogether and going to a flat rebate on brand drugs. Wouldn't it be irresponsible for Congress to even consider making changes based on the current rebate rates without first taking a very close look at how current policies may be preventing Medicaid from getting the highest possible rebates on brand drugs?

Answer:
The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called lowest private market price or best price. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. The Administration proposes replacing best price with a budget neutral flat rebate. Eliminating best price and revising the rebate percentage to offset the cost would allow private purchasers to negotiate lower drug prices. This proposal will have no effect on the Medicaid budget.

Question 7:
This question is a follow up to a question I posed regarding CMS policy on the treatment of "authorized generics" – generic-labeled versions of drugs that are produced by a brand manufacturer on the same manufacturing lines as the brand-labeled drugs and marketed under the brand's new drug application. As I stated in that question, I am extremely troubled by what appears to be an inconsistency in CMS policy which could be costing the Medicaid program millions of dollars in excess drug spending.

You have stated several times that CMS treats an authorized generic as the same as an innovator drug. However, it is my understanding that this policy only applies when CMS is deciding which rebate should be paid on the authorized generic version of the drug, and that it does not apply when CMS decides what rebate should be paid on the brand drug. Instead, in the latter instance, CMS treats an authorized generic as different from the brand drug, which allows the brand company to escape reporting the price of the authorized generic when it reports its "best price" to the Medicaid program.

In my view, the effect of this policy is to prevent Medicaid from getting the highest brand rebates allowed under law. I therefore strongly recommend that CMS take immediate steps to close this loophole and require that the price of an authorized generic be included in "best price" reporting required by Medicaid for the purpose of calculating the rebate to be paid on brand drugs. Your staff has indicated, in communication with my office, that such a change in policy could be accomplished administratively, through CMS's normal rule-making procedures, and would not require a change in the statute. Would you please confirm that CMS does in fact have authority to make such a policy change using administrative procedures?

Answer:
As we have indicated previously, we believe that this policy could be changed without a change in the statute.

The Honorable Gordon Smith

Question 1:
Recently, health officials in New York City were alarmed after a man infected with a highly drug-resistant strain of HIV progressed to full-blown AIDS within months of diagnosis. The man's HIV strain proved to be resistant to three of the four available types of antiviral drugs used to keep HIV in check. Even more alarming to health officials was the fact that the patient has already progressed to full-blown AIDS -- something that typically takes more than 10 years after initial HIV infection. This occurrence was one of the primary reasons why the Early Treatment for HIV Act (ETHA) was reintroduced last week.

Do you support giving states the option to extend Medicaid coverage to people infected with HIV so they can receive treatments before progressing to full-blown AIDS?

Answer:
This proposal is not included in the President's FY 2006 Budget. The President's FY 2006 Budget proposal supports care for HIV by providing $2.1 billion in funding for the Ryan White Care Act. The Act provides individuals living with HIV case management to assist with drug regimens, psychological support and other services. Additionally, the Ryan White Care Act funds the AIDS Drug Assistance Program (ADAP), which helps states provide medications for the treatment of HIV disease and pay for services that enhance access, adherence, and monitoring of drug treatments.

The Administration supports the reauthorization of the Ryan White Care Act. Much has changed in epidemiology and the medical management of HIV/AIDS. The Administration believes reauthorization offers an opportunity to make this important program more responsive to those whom it serves.

The Honorable Olympia J. Snowe

Question 1:
When residents train in physician offices and other "nonhospital sites," the supervising physician, in the vast majority of cases, is doing the supervising on a volunteer basis, according to the HHS Office of Inspector General (OIG) December 2004 report on "Alternative Medicare Payment Methodologies for the Costs of Training Medical Residents in Nonhospital Settings." This is a longstanding tradition within medicine. Physicians enjoy having residents train with them because it adds vibrancy to their practices, gives them an opportunity to "pass on" skills and knowledge, and enables them to "give back" to their profession.

Based on recent discussions with CMS staff, it appears that hospitals cannot claim the time residents spend in these nonhospital sites for Medicare Graduate Medical Education (GME) payment purposes, unless the hospitals actually pay the supervisory physician some amount, i.e., the hospital must incur "supervisory costs." This appears to be the case even though hospitals pay the residents' stipends and benefits during the time spent at the nonhospital site.

If physicians want to be paid for their supervisory time, then CMS' policy appears reasonable. However, if the physician is willing to volunteer and does not want to receive any supervisory payments, the hospital should be allowed to claim that resident time. Shouldn't the hospital and physician (or physician group) be allowed to determine the level of supervisory costs, if any, rather than having the government issue a directive that fundamentally changes a system that has worked very well for years?

Answer:
With today's technological advancements, the delivery of medical care is shifting to the non-hospital setting. As you know, in the Balanced Budget Act of 1997, the Congress recognized this shift, encouraging resident training in non-hospital settings, such as clinics and physician offices and to better promote resident training in rural and underserved areas.

Volunteer physician faculty is an important resource for graduate medical education programs, especially in non-hospital settings. Volunteerism is certainly encouraged under the Medicare program and we are doing everything we can under the statute to facilitate the use of such volunteer faculty.

As you know, Medicare graduate medical education payments compensate hospitals for the direct and indirect costs they incur in training residents. The Social Security Act requires that hospitals incur "all or substantially all" of the training costs at the non-hospital site in order to count the medical resident training at the non-hospital site in their full-time equivalent (FTE) count and receive Medicare graduate medical education payments. To implement the statute, we are obligated to make certain that the hospital incurs substantially all of the costs of training the residents at the non-hospital site including (1) the cost of residents' salaries and fringe benefits; and (2) the portion of the teaching physicians' salaries and fringe benefits that are related to the supervision of resident trainings in the non-hospital setting.

Recognizing the value of training more residents in non-hospital sites, we intend to make sure our rules are clear and encourage this activity. We have recently posted on our website a list of frequently asked questions (FAQs) and answers on volunteerism and Medicare graduate medical education payments to clarify our policy for hospitals, non-hospital sites, and physicians. We understand that some members of

the academic medical community have some concerns with these frequently asked questions, and we are working to further clarify our FAQs in response to these concerns.

Although the statute requires the hospital to incur all or substantially all of the training costs at the non-hospital site, the questions and answers identify specific situations in which there are no costs and, in these situations, the hospital can count the resident in its FTE count and receive Medicare graduate medical education payments for the resident's training. Additionally, we are also looking at our audit guidelines addressing this issue to make sure they are clear and consistent.

The Honorable Craig Thomas

Question 1:
Secretary Leavitt, during your confirmation process, you indicated that rural health care issues would remain a top priority at the Department of Health and Human Services. As you know, I worked hard – along side many of my Finance Committee colleagues – to include a $25 billion rural equity package in the Medicare bill. This was the first comprehensive attempt to put rural and frontier providers on a level playing field with their urban counterparts.

While this measure went a long way toward narrowing the gap in payment differences, it was not intended to be the sole revenue source to shore up our nation's fragile rural health care networks. The Medicare rural equity provisions do not address other significant issues facing rural communities such as:

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

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

That is why I was disappointed to see significant cuts to the Health Resources and Services Administration (HRSA) budget – eliminating or drastically reducing funding for critical rural programs such as:

- The Rural Hospital Flexibility (FLEX) Grant Program

- The Small Hospital Improvement Program

- The Rural Health Care Services Outreach and Network Development Grant Programs, and

- The Rural Access to Emergency Devices Grants

These initiatives have proven themselves to be effective and efficient programs that yield results. I am hopeful that you can give me specific reasons as to why the President chose to severely cut or eliminate these critical rural programs, and what the Administration will do to ensure folks in my state (particularly the uninsured and non-Medicare or Medicaid eligible) will have access to the health care services they need.

Answer:
HHS administers over 200 health and social service programs providing resources to rural areas. The Medicare Modernization Act will increase rural area payments in excess of $20 billion dollars over the next 10 years and the Community Health Center budget for 2006 of $2 billion dollars includes a proposed increase of $304 million dollars. Approximately 50 percent of the community health centers are located in rural areas and the increases approved will be apportioned to rural areas in like manner. These health care reimbursement and service delivery programs are addressing the need to imbed increasing attention to rural health care within the fabric of our major ongoing programs even as we retire those planning programs that have largely served their purpose.

The primary objectives of several of the Rural Health programs were development-oriented and have met their original program goals. For example, the Rural Hospital Flexibility Grant program was intended to support States in determining if rural hospitals would benefit from conversion to Critical Access Hospitals (CAHs). The majority of CAH conversions have already occurred over the last several years of State activity in policy planning and CAH candidate identification. Similarly, the Rural Access to Emergency Devices Grants program investment over several years has largely met the need, while the FY 2006 request will allow targeted investments in the few remaining areas of need.

To continue a rural health focus in general, specific funding is maintained in the FY 2006 budget request for certain rural health research and telehealth activities as well as funding for State offices of rural health while we move toward more rural health funding in our core entitlement and service delivery grant programs.

PREPARED STATEMENT OF HON. GORDON SMITH

Thank you, Mr. Chairman, for hosting today's hearing to discuss the President's budget for the Department of Health and Human Services. Today's hearing will prove to be a valuable resource for all of us as the Senate begins its work to develop its budget for fiscal year 2006.

First, let me say what a pleasure it is to see you again, Secretary Leavitt. I enjoyed the conversations we had during your confirmation hearing. I'm excited to see you here as the 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 understand many of the budgetary issues that will be raised today by the members of the committee.

Today, one of the topics that will be discussed 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. The President's budget reduces Medicaid funding by $60.1 billion over the next 10 years, with $1.1 billion of that coming in fiscal year 2006. Due to the relatively small reduction in the budget next year, I urge you to forgo those spending cuts and consider a review of the entire Medicaid program before moving forward. 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.

As we review the Medicaid program, I must thank you for including proposals that will make the Medicaid program more flexible. 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. The President's budget includes a demonstration 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. In the 108th Congress, I introduced legislation with Senator Harkin that would carry out this demonstration. We will be reintroducing that bill shortly, and I look forward to working with you to see it become law.

I also am pleased to see that the President has included increased funding for the AIDS Drug Assistance Program. This $10-million increase will be well-spent in helping people with AIDS get access to more affordable treatments. However, I fear it is not enough. For the past few years I have championed an effort to increase funding for ADAP by $217 million. You see, in Oregon alone there are approximately 4,500 people living with HIV/AIDS and approximately 150 more newly detected infections annually. Of these, an estimated 40 percent of those Oregonians are not receiving care for their disease. It is important to me that we help these people in my State.

Another, more comprehensive approach is to provide coverage through Medicaid. I have introduced legislation, the Early Access to HIV-AIDS Treatment Act or ETHA that would provide States the option of expanding Medicaid coverage to individuals living with HIV. Independent actuaries have found that over 10 years, my bill would reduce the death rate for persons with HIV on Medicaid by 50 percent, and over 10 years the bill would save $31.7 million. It is my hope that we can be creative when working with the Medicaid program to find opportunities, like the

Early Treatment for HIV Act, to save money while at the same time helping people who are in desperate need of our help.

The President's budget includes $1.003 billion for health centers, which is an increase of $303 million over the fiscal year 2005 level. I fully support your efforts to expand the number of health centers nationwide. In Oregon, health centers provide care for some of our most needy individuals. The President's proposal to target "high-need counties" with a portion of this funding encourages me. Much of the State that I represent is rural and is in desperate need of greater access to health care providers. Thank you for working to ensure that the people that reside in these high-need areas are served.

As you know, mental illness is a personal issue for me, and 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. The President's budget includes $11.5 million for the Garrett Lee Smith Memorial Act. Full funding for the Act would be $27 million. I will be working for full funding this year, and your support would be invaluable to me as we work through the appropriations process.

I also must thank you for supporting the Vaccines for Children program. As you know, missed opportunities to vaccinate children are a major barrier to timely immunizations. The program in Oregon aims to help Oregon reach its goal of having 90 percent of our children up-to-date with their immunization series by age 2. Currently, 76.5 percent of Oregon's children are immunized on time. It is my hope that I can help the State meet its goal. I have been working with my colleagues on the committee to expand this program to allow local and county health centers to distribute immunizations under the program. I am encouraged that the President's budget includes this proposal, and I will be working with you ensure that the proposal is passed into law. I also seek your support in removing the price cap for pre-1993 vaccines and to allow you to sell stockpiled vaccines to public health department to raise money to procure pediatric vaccine stockpiles.

Congress, as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), modified the SSI program to include a 7-year time limit on the receipt of benefits for refugees and asylees. This policy was intended to balance the desire to have people who emigrant to the United States become citizens with an understanding that the naturalization process also takes time to complete. To allow adequate time for asylees and refugees to become naturalized citizens, Congress provided the 7-year time limit before the expiration of SSI benefits. Unfortunately, the naturalization process often takes longer than 7 years, because applicants are required to live in the United States for a minimum of 5 years prior to applying for citizenship, and the INS often takes 3 or more years to process the application. Because of this time delay, many individuals are trapped in the system faced with the loss of their SSI benefits. I am encouraged that the President's budget includes funding to allow refugees and asylees to receive SSI for an additional year. I will be introducing legislation that will allow refugees and asylees to receive SSI for an additional 2 years. It is my hope that you will support a 2-year extension for refugees and asylees.

Thank you for your time, Secretary Leavitt, and I look forward to working with you in your new capacity as Secretary of the Department of Health and Human Services.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. CRAIG THOMAS

Today the Senate Finance Committee is meeting to hear testimony from Health and Human Services Secretary Michael Leavitt regarding the President's fiscal year 2006 health care budget. I look forward to hearing about the administration's health care funding priorities and its vision to modernize and reform the Medicaid program.

I believe the American health system is at a crossroads. If we continue along our current path, health care costs will continue to rise rapidly, and more Americans will be priced out of the system. This will only increase the financial burden on Federal, State, and local governments. We must begin acting today to make the difficult decisions we face regarding the future of the Medicare and Medicaid programs. We have an unprecedented opportunity to work together to ensure the sustainability and viability of these entitlement programs for years to come. It is also critically important to me and my State that we also ensure rural providers are paid adequately, and rural residents have access to necessary health care services.

I commend the Department's efforts to implement a "Rural Initiative" to improve the Agency's responsiveness to our rural communities. Also, the decision by HHS to serve as the government agency that reviews J–1 visa waiver applications so foreign doctors can practice medicine in America is crucial to many of our rural and frontier underserved areas. These remote towns have difficulty recruiting American doctors to practice in their area, and the J–1 visa waiver program has provided an important opportunity for these vulnerable communities to maintain physician services for their residents.

I am disappointed, however, the administration has cut rural health programs by approximately $115 million. Rural Health Outreach and Network Development Grants, Rural Health Research Grants, and Rural Hospital Flexibility Grants have proven to be effective and efficient programs that have a significant impact on the rural health care delivery system. While I certainly understand we are operating in a tight fiscal framework, I also believe these programs should not be undervalued.

The Medicare bill we passed offers seniors access to prescription drug plan coverage modeled after the Federal Employees Health Benefit Plan (FEHBP). The FEHBP has proven to be a good model for giving folks the same health plan choices no matter where they live. Congress increased seniors' ability to choose the type of health plan that best meets their individual needs while utilizing the private market to offer more modern and efficient health plan options.

Most importantly, the MMA offers large savings in drug costs for rural beneficiaries. As co-chair of the Senate Rural Health Caucus, I will be monitoring implementation closely to make certain rural Medicare beneficiaries have access to the same types of prescription drugs and health insurance coverage options as urban seniors.

I do have concerns about the long-term costs of this legislation, and it is important to keep that in mind as the program becomes fully operational in 2006. I am pleased, however, that together, we have taken the first steps toward bringing Medicare in line with modern medical practices.

The Medicaid program is also at a critical juncture, as its skyrocketing program costs have pushed the vast majority of States into budget deficit situations. Governors have proven to be extremely innovative in delivering health care to their most vulnerable populations, and the Federal Government should give them the flexibility to tailor programs that best meet the needs of their States. I look forward to hearing more details about the administration's efforts in this area.

I thank Secretary Leavitt for his comments today, and I look forward to working with the administration on strengthening our Nation's rural health care delivery system.

Thank you, Mr. Chairman.

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