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HHS Leadership in Federal Emergency Preparedness Efforts

Statement of

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Good morning Chairman Waxman, Ranking Member Davis, and other distinguished Members of the Committee. I am pleased to discuss HHS leadership in Federal public health and medical emergency preparedness efforts, as well as HHS and CMS efforts to ensure that Medicaid pays appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid.

Emergency Preparedness

Local, state, and federal agencies have a shared responsibility for ensuring that the nation is prepared for emergencies. Before an event, government agencies at all levels work with the private sector to plan and exercise so they can be ready when a disaster occurs. During an emergency, local and state response agencies, including public health departments, are the first to respond. For multi-state or severe emergencies, the federal government may be asked to provide additional resources and coordinate response efforts across multiple jurisdictions. In that context, permit me to briefly discuss a few of the emergency preparedness efforts currently being led by HHS that involve working with our Federal, State, and local partners.

Homeland Security Presidential Directive (HSPD)-21

On October 18, 2007 President Bush signed Homeland Security Presidential Directive (HSPD)-21, "Public Health and Medical Preparedness," establishing a new National Strategy for Public Health and Medical Preparedness (the

Strategy). The Strategy aims to improve the Nation's ability to plan for, respond to, and recover from public health and medical emergencies at the Federal, State, Territorial, Tribal, and local levels. It calls for the continued development of a National Health Security Strategy, as well as a robust infrastructure -- including healthcare facilities, responders and providers -- which can be drawn upon in the event of an emergency. The Strategy also requires actions to ensure the adequate flow of information before, during, and after an event, including critical biosurveillance data and risk analysis. Finally, the Strategy calls for the development of resources at the community level to ensure that individuals and families are empowered to protect themselves in the event of an emergency.

In order to implement the actions outlined in the Strategy, the HSPD establishes an interagency Public Health and Medical Preparedness Task Force, led by the Secretary of Health and Human Services. In December 2007 an Assistant Secretary-level meeting of the 12 Departments that make up the Task Force was convened. Since then, HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) has chaired two interagency Action Officer level meetings to provide guidance on implementation.

HSPD-21 mandates the development of an Implementation Plan, which provides detailed information regarding how the Federal Departments and Agencies will execute these actions. HHS chairs the interagency Writing Team that drafted the Implementation Plan, which is currently in the process of being finalized.

Six workgroups have been established to oversee implementation of HSPD-21. Four workgroups are being chaired by HHS: (1) Medical Countermeasure Stockpiling and Distribution; (2) Biosurveillance; (3) Mass Casualty Care; and (4) Community Resilience. A fifth workgroup on Education and Training is co-chaired by HHS and DOD and a sixth workgroup on Risk Awareness is being chaired by the Department of Homeland Security.

HSPD-21 directed the establishment of two advisory committees. The National BioSurveillance Advisory Committee has been established as a subcommittee to the Centers for Disease Control and Prevention (CDC) Advisory Committee to the Director (ACD) and a Disaster Mental Health Advisory Committee is being established as a subcommittee under the National Biodefense Science Board (NBSB) which advises the HHS Secretary.

Emergency Care Coordination Center (ECCC)

Finally, HHS is implementing HSPD #21, including through the establishment of the Emergency Care Coordination Center (ECCC). This new center, an intradepartmental and interdepartmental collaborative effort involving the Departments of Defense, Homeland Security, Transportation and Veterans Affairs, will serve as the coordinating focal point for an Emergency Care Enterprise, coordinating with the Federal Interagency Committee on Emergency Medical Services. Its vision is exceptional daily emergency care for all persons of the United States and its mission is to promote Federal, State, local, tribal and

private sector collaboration to support and enhance the nation's emergency medical care.

The ECCC will assist the USG with policy implementation and guidance on daily emergency care issues and promote both clinical and systems-based research. Through these efforts, ASPR and its federal partners will improve the effectiveness of pre-hospital and hospital based emergency care by leveraging research outcomes, private sector findings and best practices. The ECCC will promote improved daily emergency care capabilities to improve resiliency of our local community healthcare systems. This will provide a stronger foundation on which to advance disaster preparedness efforts and strengthen our Nation's ability to respond to mass casualty events. Currently, the ECCC Charter is being finalized and we anticipate having the Center up and running by the end of the year.

Emergency Support Function 8 (ESF#8)

The National Response Framework (NRF) Emergency Support Function (ESF) #8 – Public Health and Medical Services – provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. The Secretary of Health and Human Services (HHS) leads all Federal public health and medical response to public health

emergencies and incidents covered by the *NRF.* The response addresses medical needs and other functional needs of those requiring medical care and other assistance during an emergency.

Except for the personnel and assets under armed forces command, the Secretary of HHS assumes operational control of Federal emergency public health and medical response assets, as necessary, in the event of a public health emergency. The Secretary of HHS, through ASPR, coordinates national ESF #8 preparedness, response, and recovery actions.

National Disaster Medical System (NDMS)

We are also continuously improving HHS's operational capabilities to respond to emergencies. The National Disaster Medical System (NDMS), transferred from the Department of Homeland Security to HHS, remains the "tip of the spear" as the federal disaster healthcare response capability, maintaining 6,200 medical and public health professionals and over 1,800 participating hospitals with approximately 32,000 beds. Since the transfer of NDMS last year, we have achieved a number of accomplishments aimed at improving the System including the integration of NDMS into the larger Emergency Support Function #8 (ESF-8) response framework and regionalization of NDMS response operations and caches to provide increased accountability and standardization for supplies as well as fiscal savings. Future goals for NDMS include enhancing readiness and

accountability through regionalization of NDMS response operations and enhancing equipment caches.

Hospital Preparedness Program (HPP)

We have made considerable investments in building the healthcare preparedness and response capabilities required during an incident resulting in mass casualties, and are committed to performance measurement. Over the past five years, the Hospital Preparedness Program (HPP) has provided more than $2.6 billion to fund the development of medical surge capacity and capability at the State and local level. As a result of HPP funds awarded to states and territories, hospitals and other healthcare entities:

- Increased their ability to provide needed beds during an emergency;
- Can now track bed and resource availability using electronic systems;
- Engaged with other responders through interoperable communication systems;
- Appropriately train their healthcare workers for all-hazards approach to emergencies,
- Protect their healthcare workers with proper equipment;
- Have installed equipment necessary to decontaminate patients;
- Have developed fatality management and hospital evacuation plans, and
- Coordinate regional exercises.

Pandemic and All-Hazards Preparedness Act (PAHPA)

Consistent with requirements contained in the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), HHS has updated the performance measures for our funding programs. Specific improvements include greater clarity in language, the use of definitions, and the addition of targets. For example, in FY 2006, HHS asked grantees to report participating hospitals' ability to track bed status electronically, and report it to the grantee's Emergency Operations Center within 60 minutes of a request. In 2007, the numerator and denominator were defined to improve clarity. For FY 2008, the target percentage of hospitals able to report was increased to 100 percent by the end of the end of the year.

HHS strongly supported the new accountability provisions included in PAHPA and is implementing these provisions. First, FY 2009 award funds will be based on the successful achievement of targets during the previous budget cycle. In addition, the matching provision will be applied to the Public Health Emergency Preparedness Program (PHEP) in FY 2009. We also intend, through notice and comment, to apply the matching provision to the Hospital Preparedness Program (HPP) in FY 2009. The audit and carryover provisions apply to both the PHEP and HPP programs currently; the withholding provision will be applied to these programs in FY 2009. The HPP and PHEP programs implemented the maintenance of funding provision in FY 2007.

Public Health Emergency Preparedness (PHEP) Program

From FY 2002- FY 2007, the Public Health Emergency Preparedness (PHEP) program has provided $5.6 billion to state, local, tribal, and territorial public health departments. This amount includes targeted supplements to prepare for smallpox (in FY 2003) and for an influenza pandemic (FY 2005 – FY 2007). This program has greatly increased the preparedness capabilities of public health departments:

- All states can receive and evaluate urgent disease reports 24/7, while in 1999 only 12 could do so.
- All states now conduct year-round influenza surveillance.
- The number of state and local public health laboratories that can detect biological agents as members of CDC's Laboratory Response Network (LRN) has increased to 110 in 2007, from 83 in 2002. For chemical agents, the number increased to 47, from 0 in 2001. Rather than having to rely on confirmation from laboratories at CDC, LRN laboratories can produce conclusive results. This allows local authorities to respond quickly to emergencies.
- All states have trained public health staff roles and responsibilities during an emergency as outlined in the Incident Command System, while in 1999 only 14 did so.
- All states routinely conduct exercises to test public health departments' ability to respond to emergencies. Such exercises were uncommon before PHEP funding.

Preserving the Medicaid Partnership

Medicaid, along with Medicare and other private payers, is an important source of funding for the American health care system. It is important to remember, however, that Medicaid is fundamentally a Federal-State commitment to provide health care for Medicaid beneficiaries. And, first and foremost, our responsibility is to assure that these low-income seniors, children, pregnant women, and people with disabilities are able to receive high quality and appropriate care when they need it.

The package of recent Medicaid regulatory activity will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. As CMS and others have previously testified, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program, to the greatest extent possible, to the Federal government. Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations.

Additionally, GAO and OIG have provided policymakers with numerous reports on various areas in which States engage in activities to maximize Federal revenues. Here are just a few examples:

- The GAO found several States "used several financing approaches to maximize federal Medicaid contributions without effectively committing

their share of matching funds. Under these approaches, facilities that received increased Medicaid payments from the states, in turn, paid the states almost as much as they received. Consequently, the states realized increased revenue that was used to reduce their state Medicaid contributions, fund other health care needs, and supplement general revenue funding."

- State agencies paid private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in State custody, and based their claims on facilities' estimated costs rather than actual costs. This resulted in an increase of $58 million in Federal Medicaid reimbursements.
- Medicaid is frequently billed for costs related to transporting children from home to school and back on a given school day despite the fact that children are transported to school primarily to receive an education, not to receive medical services. In a 2004 review of one state, OIG found that more than 90 percent of transportation claims to Medicaid, made on behalf of almost 700 schools and preschool providers over the September 1, 1993 through June 30, 2001 period, were not in compliance with Federal and State regulations.

These rules address these types of abuses head-on by ensuring that Federal Medicaid dollars are matching actual State payments for actual Medicaid services to actual Medicaid beneficiaries. Medicaid is already an open-ended

Federal commitment for Medicaid services for Medicaid recipients; it should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.

When Medicaid funds are diverted to purposes not expressly authorized by law, legislatures have not had the opportunity to determine if such funding is warranted or desirable. As a result, the legislative decision-making process is weakened. This is especially true at the State level as Medicaid now typically accounts for one out of every five dollars spent by States. The Medicaid program should be based on transparency and trust, not on hidden funding arrangements that result in a "don't ask, don't tell" relationship with oversight agencies.

CMS is often asked why we cannot simply stop these practices through the audit and disallowance process. Audits and disallowances occur on the back end of the process. Obviously it would be better if there were no opening for practices that are inconsistent with the overall statutory and regulatory framework. The rules listed below would help eliminate perceived ambiguities and protect the federal-state financial partnership.

Final Medicaid Governmental Provider Payment Rule

The Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership rule requires that Medicaid payments to governmentally-operated health care providers not exceed

an individual provider's cost. This will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

To the extent that a provider is not governmentally operated, this rule does not impact Medicaid payments made to them by the State. The rule would simply offer further protection against States requiring non-governmental providers to assist in the funding of the Medicaid program as well as clearly stating that the provider must retain all of the Medicaid payments it receives. To the extent that a provider is governmentally operated, this rule stipulates that the provider is entitled to receive Medicaid payments up to their full cost of providing services to Medicaid eligible individuals.

The Federal government is not reducing, restricting, or limiting the Federal commitment to pay the full cost of providing medically necessary services to Medicaid recipients as long as the States are contributing their full share as well.

Proposed Rule on Graduate Medical Education

The proposed rule makes Medicaid graduate medical education (GME) payments and costs ineligible for Federal financial participation (FFP). Specifically, the proposed rule no longer allows States to include GME as a payment under the Medicaid State plan or as an allowable cost in determining

Medicaid payments. There is no explicit authorization under the Medicaid statute to subsidize the training of physicians. In a time of limited Federal and State resources, it is important to prioritize Medicaid spending and target it to its primary purpose.

Final Rule on Provider Taxes

This final rule (1) revises the threshold from 6 percent of net patient revenue to 5.5 percent under the first prong of the indirect hold harmless guarantee test as enacted by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432); (2) clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test; (3) codifies changes to permissible class of health care items or services related to managed care organizations (MCO) as enacted by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171); and (4) removes obsolete transition period regulatory language. We believe that this rule faithfully reflects the intent of Congress in enacting the provider tax rules in 1991 and the minor revision in TRHCA.

Proposed Rule on the Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap

could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital.

Final Rule on the Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

This rule clarifies that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. The rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law.

Interim Final Rule with Comment on Targeted Case Management

The interim final rule clarifies the definition of covered case management services and implements Section 6052 of the Deficit Reduction Act of 2005, which redefined the scope of allowable case management services, strengthened State accountability, and required that CMS issue regulations. The work of GAO and the OIG was key to our understanding that some States were claiming case management expenditures that were not supported by actual activities to improve the health status of Medicaid recipients. It is important to remember that the point of the Medicaid program is to improve the availability of health services and the health status of program beneficiaries, not simply as a supplement for state and local budgets.

This interim final rule has a strong emphasis on ensuring that case management will be comprehensive and coordinated, to fully serve beneficiary needs. High quality case management should result in better outcomes for the individual and better value for the taxpayer.

Proposed Rule on Rehabilitative Services

In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a "catch all" phrase. The proposed regulation clearly defines allowable services that may be claimed as "rehabilitative services."

This proposed rule will also include important beneficiary protections to improve the quality of care provided to the individuals who need these rehabilitative services. For the first time, rehabilitative services would be required to be furnished through a written plan of care that identifies treatment goals and methods. Our proposed rule contemplates that care will have a clear foundation in clinical practices, and will be designed and delivered in a patient centered environment.

Conclusion

These rules reflect the long-standing work of CMS and others, such as GAO and the OIG, to restore greater accountability to the Medicaid program, while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. As I have testified, HHS is working diligently to improve our nation's emergency preparedness and medical surge capacity, and we have made extensive funding available to hospitals through the states specifically toward this end.

Medicaid, however, is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program, and allowing for the continuation of abusive practices of shifting costs to the Federal government is not the appropriate way to ensure our nation's preparedness. As Medicaid competes for resources at the State level against all the other demands that are present, an

erosion of confidence in the integrity of the Medicaid program ultimately is not good for Medicaid or for the people who rely on it.

We are committed through our emergency preparedness efforts to continue to make progress and make funding available to states, while acting through these Medicaid rules to provide greater stability in the program and equity among the States.

Thank you for the opportunity to testify today; I am happy to take any questions you may have.