FISCAL YEAR 2012 HHS BUDGET AND THE IMPLEMENTATION OF PUBLIC LAWS 111–148 AND 111–152

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

MARCH 3, 2011

Serial No. 112–14

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

67–590 PDF WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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SUBMITTED MATERIAL

FISCAL YEAR 2012 HHS BUDGET AND THE IMPLEMENTATION OF PUBLIC LAWS 111–148 AND 111–152

THURSDAY, MARCH 3, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:31 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Pitts, Burgess, Whitfield, Shimkus, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Barton, Upton (ex officio), Pallone, Dingell, Towns, Engel, Capps, Schakowsky, Gonzalez, Baldwin, Weiner, and Waxman (ex officio).

Also present: Representative Green.

Staff present: Ryan Long, Chief Counsel; Howard Cohen, Chief Counsel; Clay Alspach, Counsel; Marty Dannenfelser, Senior Advisor; Julie Goon, Health Policy Advisor; Brenda Destro, Professional Staff; Paul Edattel, Professional Staff; John O'Shea, Professional Staff; Monica Popp, Professional Staff; Heidi Stirrup, Health Policy Coordinator; Jimmy Widmer, Health Intern; Alex Yergin, Legislative Clerk; Phil Barnett, Democratic Staff Director; Stephen Cha, Democratic Senior Professional Staff Member; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Purvee Kempf, Democratic Senior Counsel; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; Rachel Sher, Democratic Senior Counsel; and Mitch Smiley, Democratic Assistant Clerk.

Mr. PITTS. This subcommittee will come to order. In light of the interest in hearing from our distinguished witness today, and so that every member of this subcommittee may have time to answer questions, we will be strict in enforcing our time limits today. That is 5 minutes for questioning and that is questioning and answers. So don't ask a 5 minute question and then ask the Secretary to then try to respond in the remaining seconds. And we have agreed to 3 minute opening statements. And Chair will recognize himself for an opening statement. It is 3 minutes.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. I would like to welcome our distinguished witness today, the Honorable Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services. Madame Secretary, thank you for your time and your testimony today. The Department of Health and Human Services is a large department with broad authority and jurisdiction. With the enactment of the Patient Protection and Affordable Care Act, PPACA, we have found that there are several sections of this new law that require mandatory funding, hence bypassing the normal appropriations process.

Today's hearing will give us a chance to examine these provisions and consider the budgetary implications for implementation and administration of this new law. One aspect that I am concerned with is the Office of Consumer Information and Insurance Oversight, OCIIO. Less than a month after PPACA passed last year, the Department moved regulation of health insurance from the Centers for Medicare and Medicaid Services where it had been for years to a new office OCIIO which reports directly to the Secretary. Then in January of this year, the Secretary announced that OCIIO would be moving and would now be housed at CMS. This is interesting because OCIIO implements and regulates many of the new healthcare's private insurance provisions and CMS runs the Nation's public health programs. The office has been in the news lately for granting over 900 waivers to private health plans unable to meet various standards set by Obamacare. It is important to note that the OCIIO was not authorized nor even mentioned in Obamacare, yet the President's budget request includes a $1 billion increase for program management discretionary administration at CMS. It appears that this additional $1 billion will be funding OCIIO. I will be interested in learning more about this new office and the role it plays. And I look forward to seeing more transparency in the Department's budget. And for my remaining time I yield to the gentlelady from Tennessee, Ms. Blackburn.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

I would like to welcome our distinguished witness today, the Honorable Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services. Madame Secretary, thank you for your time and testimony.

The Department of Health and Human Services is a large department with broad authority and jurisdiction. With the enactment of the Patient Protection and Affordable Care Act (PPACA), we have found there are several sections of this new law that require mandatory funding - hence, bypassing the normal appropriations process.

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One aspect I am concerned with is the Office of Consumer Information and Insurance Oversight (OCIIO).

Less than a month after PPACA passed last year, the Department moved regulation of health insurance from the Centers for Medicare and Medicaid Services (CMS), where it had been for years, to a new office, OCIIO, which reports directly to the Secretary.

Then, in January of this year, the Secretary announced that OCIIO would be moving and would now be housed at CMS.

This is interesting because OCIIO implements and regulates many of Obamacare's private insurance provisions, and CMS runs the Nation's public health programs.

The Office has been in the news lately for granting over 900 waivers to private health plans unable to meet various standards set by Obamacare.

It is important to note that the OCIIO was not authorized nor even mentioned in Obamacare, yet the President's budget request includes a $1billion increase for ″program management discretionary administration″ at CMS. It appears that this additional $1 billion dollars will be funding OCIIO.

I will be interested in learning more about this new Office and the role it plays. I look forward to seeing more transparency in the Department's budget.

I yield to the gentlelady from Tennessee, Mrs. Blackburn.

Thank you.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and I do welcome the Secretary and I will pick up right where Mr. Chairman left off with transparency. And I think what is astounding to many is the lack of transparency in this process and the difficulty with getting information. We know that our States have fought the battle indeed; not only companies, but States are receiving waivers. What we see in front of us, Madame Secretary, seems to be a confused process. Our States are frustrated. We have heard from State Legislators, from Governors—they are all beginning to agree with your former colleague Governor Bredesen who called this the mother of all unfunded mandates and with others who said, you know, it is too expensive to afford and this is something that would bankrupt the States. There is just truly a dissatisfaction, and one of the things I will highlight with you today and question with you is my concern over lack of response and in the adequate response to questions. Yield back.

Mr. PITTS. Chair thanks gentlelady and yields to the ranking member, Mr. Pallone, for 3 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and I want to welcome Secretary Sebelius. In these tough economic times I recognize how difficult budgetary and spending decisions are for the President and this Congress. I commend the President for his responsible budget. I only hope that we can work together to move this country forward to create jobs and to foster economic growth.

And I want to commend Secretary Sebelius for your agency's hard work this past year to implement the Affordable Care Act. I will continue to fight against the Republican efforts to defund this important landmark law. I can't agree more with President Obama that as we continue to work our way out of the recession towards a thriving economy that offers economic opportunities for all Americans that we must out-innovate, out-educate, and out-build the rest of the world. And to do that I believe the Federal Government has a vital role to play.

At the core of innovation is research and development. It is R&D that propels the science and the business of healthcare. In fact, a recent report show that healthcare R&D supports 211,000 jobs, and $60 billion in economic activity in my State of New Jersey. But R&D requires resources. Investments made by Government can help research projects get off the ground and leverage resources off

the private sector and academia. And that is why I was very pleased to see that the President's budget includes Government investments and healthcare R&D. His budget recognizes that key agencies like NIH and FDA are essential to facilitate an environment where Americans can continue to innovate.

I did want to mention, however, my disappointment in one program. That is the termination of the Children's Hospital Graduate Medical Education Program. This has reverse declines in pediatric training programs that had threatened the stability of the pediatric work force and the small class of hospitals that receive this funding which includes the Children's Specialized Hospital in my district represents about one percent of hospitals nationwide, but trains approximately 40 percent of all pediatricians. Eliminating this program would have a major negative impact on access to primary care and impact access to specialty care for children. But—and I wanted to mention that I am committed to reauthorizing and funding this program and introducing a bill to do that soon.

But really, I wanted to stress, Madame Secretary, that I really do think that as we move forward with the Affordable Care Act, I know the anniversary is coming up I believe on March 23, just in a couple of weeks. Already, there are so many of my constituents and so many people that I talk to that talk about the benefits of, you know, eliminating pre-existing conditions, of being able to put their children on the policies, what we have done for seniors in terms of cutting back on and eventually eliminating the doughnut hole, eliminating co-pays for preventative care. People are very much aware of the benefits of this and more and more, I think, as it continues to be implemented will be. And I am very much opposed to any efforts to defund the program particularly since we see the positive benefits from it. Thank you, Mr. Chairman.

Mr. PITTS. Thank you. Chair thanks gentleman and yields 3 minutes to the chair of the committee, Mr. Upton.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman. Two days ago, we heard from the—some of the Nation's Governors on the negative impact that the new law will have on their States in quality of healthcare. What we heard is similar to what most members hear—anytime they speak with their Governor, they express their concern that the mandates and requirements coming out of D.C. are hindering to deal with the State's problems.

The President did offer, I think, some flexibility on Monday by declaring that the States could opt out of certain aspects of the health reform law a few years early as long as they met every one of the goals. Well, I am concerned that the States will only be allowed to take advantage of the so-called flexibility if they construct a program that looks almost exactly like the system that was set up in the healthcare law. States need real flexibility without all the strings and caveats attached.

The President did call on the Governors to come up with a bipartisan proposal on Medicaid. Dozens of Governors have already asked for relief from maintenance of effort requirements so that they can direct Medicaid funds to those most in need and meet

their constitutional responsibility to balance their State budgets. If States are instead enforced to impose steep reductions out of payments to providers, they will likely drive more doctors and other providers out of the Medicaid program and in some cases out of the practice of medicine altogether. I believe that is detrimental to both patients and to the quality of care that they can expect to receive. If the President wants a bipartisan Medicaid proposal, then we need to repeal the maintenance of effort is the place to start, and I hope that the Administration will work with members of this committee to expeditiously repeal those requirements.

I would also like to hear from the Secretary what programs at HHS she believes are redundant and duplicative. With Federal deficits as far as the eye can see, $1.6 trillion in the President's budget for 2012, we must go through the budget with a fine tooth comb. As yesterday's report from the GAO revealed that the Subcommittee on Oversight Investigations, the Federal Government is wasting tens of billions of dollars on duplication, overlap, and fragmented programs. We cannot simply fund programs because what we did last year or the year before. Every program has to be scrutinized and I look forward to working with you, and I yield the balance of my time to Mr. Cassidy from Louisiana.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Thank you, Mr. Chairman, for holding this hearing today. I remember back almost two years ago when the Secretary was asked to testify on the House health care bill, the Committee was told by the Chairman at the time that it would be unfair to ask her to testify on the specifics of the bill because she had not had time to read it. The House bill was eventually scrapped and the Senate bill became law. So this Committee never had an opportunity pose questions to the Secretary on the House bill or have any type of hearing on the bill that became law.

Although this hearing should have happened a year and half ago, it is important that we hear from the Secretary on her Department's efforts to implement the new health law. A quick search of the Patient Protection and Affordable Care Act, known as PPACA, shows the phrase "the Secretary shall" 1,051 times. That does not include the additional 24 times that phrase appears in the companion Reconciliation bill.

To be fair, the Secretary will not be making all of these determinations. In fact, many of the decisions will be delegated to unelected bureaucrats who will now be in charge of every facet of our nation's health care system. Regardless, Washington will determine what benefits are included in your insurance and what benefits you will be forced to pay for. Washington will determine if your doctor or hospital provides quality care and if in their determination they do not, then you may not be able to see them.

Section 1311 of PPACA actually has a provision that provides the Secretary the ability to spend an unlimited amount of money purportedly on State exchange grants without the need for Congressional approval or oversight. This point needs emphasis because it is unprecedented, that Congress would provide the Secretary a direct tap on the Treasury that is completely at her discretion to determine how much money she wants to spend. Americans wanted to keep their quality health care but lower the costs. Instead they got Washington control and multibillion dollar slush funds.

The Democrats want the American public to believe this law is about ten pages long. They talk about taking care of people with pre-existing conditions; they talk about ensuring that Americans will not have their insurance taken away when they get sick; and they talk about letting young adults up to age 26 stay on their parents' plan. These are all things Republicans have stated a desire to work with the Democrats on. If this was the goal of health reform, there would not have been a need for secret deals or a year and a half wasted debating the issue. Instead, the Democrats tacked on another 2,890 pages filled with an unconstitutional mandate, an unsustainable ponzi scheme, a thousand "Secretary shalls," two new, massive

unaffordable entitlement programs, numerous job-destroying mandates, and $800 billion in new taxes that will make health care more expensive and jobs harder to come by.

The President has said he doesn't want to relitigate the past and I don't either. We could talk about Cornhusker kickerbacks and multi-million dollar earmarks that were used to get the bill through, but I want to talk about how this law will bankrupt our States and our country. I think it is important to examine why all independent analysts believe this bill will hurt job and wage growth. I want to talk about how companies are afraid to invest in new employees because of the uncertainty surrounding this law, and I think all Americans should understand how this bill will dramatically harm the quality of health care in this country. I do not think that is relitigating the past;I think we owe the American people an open debate about how to preserve this country's future.

Two days ago we heard from some of the Nation's Governors on the negative impact the new law will have on their States and the quality of health care. What we heard two days ago is similar to what most members hear anytime they speak with the Governor of their State. They express their concern that the mandates and requirements coming out of Washington are hindering their ability to deal with their State's problems.

The President offered a fig leaf of flexibility on Monday by declaring States could opt out of certain aspects of the health reform law a few years early as long as they meet every one of his goals. This patriarchal perspective is somewhat condescending toward the States. In essence, the Administration is treating the States like the 16-year-old whose parents offer to buy him a new car. Parents tell their teenager they can have any car they want - the only catch is that it must meet every one of the parents' stringent requirements. Low and behold the only car that fits the bill is the family's 15-year-old station wagon. So much for choice.

It sounds a lot like one of the promises that was central to PPACA: if you liked your insurance, you could keep it. Once Americans read the fine print, they realized you could keep your plan if you liked it but only if the Secretary feels it meets her requirements. It makes me think there was an important caveat to the President's campaign slogan. It seems ″yes we can″ really meant, ″yes, we can if and only if Washington and its bureaucrats believe it is best for you.″

The President did call on Governors to come up with a bipartisan proposal on Medicaid. Dozens of Governors have already asked for relief from maintenance of effort requirements so that they can direct Medicaid funds to those most in need and meet their constitutional responsibility to balance their State budgets. If States are instead forced to impose steep reductions in payments to providers, they will likely drive more doctors and other providers out of the Medicaid program and, in some cases, out of the practice of medicine altogether. This will be detrimental to patients and to the quality of care they can expect to receive. If the President wants a bipartisan Medicaid proposal then repealing the MoE is the place to start, and I hope the Administration will work with members of this committee to expeditiously repeal the maintenance-of-effort requirements.

PPACA established permanent cuts to Medicare providers like hospitals in order to create new entitlement programs. During the debate many questioned the wisdom of taking hundreds of billions of dollars out of the Medicare program while failing to address its long-term fiscal issues, not to mention the short-term need to find hundreds of billions of dollars to reform the Medicare physician payment system to ensure that doctors continue to see seniors.

The president now proposes a two-year physician payment fix. I agree that we must fix the Medicare physician payment system, but I am deeply disappointed with those that stated they supported the same goal but then raided the program to establish new entitlements we cannot afford.

The approaches taken by the Democrats last Congress still confound me. Medicaid is bankrupting the States so Congress voted to expand it. Medicare cannot pay doctors so they raided the program to fund new entitlements. Health care is too expensive so they taxed it and increased the cost. Businesses are not hiring so they placed more mandates on them to make it more difficult to create jobs. All the while they ignored that the fact that most American liked their insurance but they wanted to find ways to make it less expensive. We can and should do better.

Mr. CASSIDY. Governor Duval Patrick testified Tuesday, that Massachusetts developed the model for Obamacare and that Massachusetts gives a vision of our future. I agree. We were told almost everything else he said, though, was false. We were told that because of this model that ER visits are down. They are not. As

it turns out, throughout—significantly according to the Urban Institute and 20 percent in western Massachusetts. We were told that the private insurance market is unaffected. Actually, fewer businesses are offering insurance and premiums are up above the national average. We were told that a cost is an issue that is being addressed and access is expanding. Actually, according to the Globe and the National Journal, people are being disenrolled and "dental benefits are being slashed to hundreds of thousands threatening their access to their dentist." Indeed the Democratic State Treasurer said if the United States implements a plan like Massachusetts, we will go bankrupt. Now the question before us today is whether we believe the vision of which we were told, or the vision that we see. I yield back.

Mr. PITTS. The Chair thanks the gentleman. Yields 3 minutes to the ranking chair of the committee, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Madame Secretary, it is a pleasure to welcome you back to our committee. First, I want to commend you on the work you are doing to implement the Affordable Care Act. That is the name of the law. The job you were given by Congress and the President is imposing but you have met it with leadership and steadfast commitment. Today's hearing is meant to address the President's budget proposal for HHS for fiscal year 2012. You wouldn't know it from the opening statements. But fiscal year 2012 seems very far away at this point. I am much more focused on the threats from the continuing resolution passed by the House. I believe the cuts proposed by the Republican budget would be just devastating to the mission of your department. The Republican proposal would cut 23 percent from the Centers for Medicare and Medicaid services. Well, this will devastate the ability of the agency to maintain its basic functions like paying Medicare claims, cracking down on fraud, and funding health programs through Medicaid and the Children's Health Insurance Program.

The FDA would see cuts of 17 percent with enforcement of the new food safety law gutted. The Centers for Disease Control would be cut by 37 percent leaving Americans more exposed to viruses and illnesses. The Community Health Centers Program which has strong bipartisan support would be cut by $1 billion closing 127 health centers and cutting off 11 million patients from care they need. Cuts of this magnitude are not belt tightening or doing more with less. They go to the heart of the core mission of the agencies that comprise HHS, jeopardize access to healthcare, research, and the safety of our food and pharmaceuticals. I agree with President Obama's guidance to us yesterday in discussing a final CR for this fiscal year. Disagreements should be bipartisan. They should be free of any party's social or political agenda, and it should be reached without delay. Thank you, Madame Secretary, for being here today and I urge you to continue to work diligently to implement the essential protections of the Affordable Care Act. And I would be pleased to yield to any of my colleagues on the Democratic side. Mr. Engel, I yield to you the rest of my time.

Mr. ENGEL. Yes, I want to second what Mr. Waxman has just said. When we look at the Republican budget we see things cut out that are really just unimaginable. You know, we heard the Governors and I know, Madame Secretary, you are a former Governor. We heard the Republican Governors come here and basically say they don't like the healthcare law. They want Government to get out of people's lives. You know if Governor Barbour is happy with Mississippi always being 49th and 50th in education and healthcare, then I suppose he will be happy with it. But some of us do feel that healthcare, affordable healthcare is a right and that is what we tried to do. And the negativity boggles my mind.

Mr. PITTS. Chair thanks the gentleman and at this time will go to our witness. I would like to introduce our witness, the Secretary of Health and Human Services, Kathleen Sebelius. Secretary Sebelius was first elected to the Kansas House of Representatives in 1986. In 1994, Secretary Sebelius was elected State Insurance Commissioner for the State of Kansas and in 2002, she was elected to be the State's Governor. Madame Secretary, we welcome you to the committee. We look forward to your testimony.

STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. SEBELIUS. Thank you very much, Chairman Pitts, Ranking Member Pallone, and members of the committee. Thank you for inviting me here today to discuss the 2012 budget for the Department of Health and Human Services.

In the President's State of the Union Address, he outlined his vision for how the United States can win the future by out-educating, out-building, and out-innovating the world so we can give every family and business the chance to thrive. And I think our 2012 budget is a blueprint for putting a portion of that vision into action. It makes investments for the future so that we grow our economy and create jobs.

But we also recognize that we can't build lasting prosperity on a mountain of debt. Years of deficits have put us in a position where we need to make tough choices. In order to invest for the future we need to live within our means. So in developing the budget we looked closely at every program in our department, and when we found waste we cut it. And when programs weren't working well we redesigned them to put a new focus on results. And in some cases we cut programs we wouldn't have cut in better fiscal times. And I look forward to answering your questions, but Mr. Chairman, I would like to start with just sharing some highlights.

Over the last 11 months we have worked around the clock with our partners in Congress and States to deliver on the promise of the Affordable Care Act. Thanks to the law, children are no longer denied coverage because of their preexisting health conditions. Families have protections in the new Patient's Bill of Rights. Businesses are getting relief from the soaring healthcare costs and seniors have lower cost access to prescription drugs and preventive care.

This budget builds on the progress by supporting innovative new models of care that will improve patient's safety and quality while reducing the rising burden of health costs on families, businesses,

cities, and States. We make new investments in our healthcare workforce and community health centers to make quality affordable care available to millions more Americans, and create hundreds of thousands of new jobs across the country.

At the same time the budget includes additional proposals that strengthen program integrity in Medicare, promote lower medicine costs, improve Medicare program operations, and reform the quality improvement organizations which help providers improve care. The budget also includes saving proposals to strengthen Medicaid. It includes funding for the Transitional Medical Assistants Program and Medicare Part B premium assistance for low income beneficiaries, programs which help keep health costs down for low income individuals and help them keep their vital coverage.

To make sure America continues to lead the world in innovation, our budget includes funding increases for the National Institutes of Health. New frontiers of research like cell-based therapies and genomics have the promise to unlock transformative treatments and cures for diseases ranging from Alzheimer's to cancer to autism. And our budget will allow the world's leading scientists to continue to pursue discoveries while keeping America at the forefront of biomedical research. And because we know there is nothing more important to our future than the healthy development of our children, our budget includes significant increases in funding for childcare and Head Start.

Science shows that success in school is significantly enhanced by high quality, early learning opportunities. These investments are some of the wisest that we can make in our future. But our budget does more than provide additional resources. It also aims to raise the bar on quality in childcare programs supporting key reforms to transform the Nation's childcare system into one that fosters healthy development and gets children ready for school; proposes a new early learning challenge fund, a partnership with the Department of Education that promotes State innovation in early education; and these initiatives combined with the quality efforts already underway in Head Start are an important part of the President's education agenda to help every child reach his or her academic potential and make our Nation more competitive.

The budget also promotes strong family relationships. It supports a child-support-and-fatherhood initiative that encourages fathers to take responsibility for their children; changes policies so that more of that support reaches the children; and maintains a commitment to vigorous enforcement promoting healthy relationships between fathers and their children. We also fund new performance driven incentives for States to improve outcomes for children in foster care such as reducing long term foster stays and the reoccurrence of child maltreatment. These children also need to be part of our better future.

Our budget recognizes that at a time when so many Americans are making every dollar count, we need to do the same. That is why the budget provides new support for President Obama's unprecedented push to stamp out waste, fraud, and abuse in our healthcare system, an effort that more than pays for itself returning a record of $4 billion to taxpayers last year alone. In addition the budget includes a robust package of administrative improve-

ments for Medicare and Medicaid. The proposals include prepayment scrutiny, expanded auditing, increased penalties for improper actions, and strengthens CMS's ability to implement corrective actions and address State activities that increase Federal spending. Over 10 years on a conservative estimate they should deliver over $32 billion in savings.

Across our department we have made eliminating waste, fraud, and abuse a top priority but we know that isn't enough. So over the last few months we have also gone through the Department's budget, program by program, to find additional savings and opportunities where we can make our resources go further.

In 2009, Congress created a grant program to help States expand healthcare coverage and we have eliminated that program because it is duplicative. CDC funding has been helping States reduce chronic diseases but the funding was split between different diseases: one grant for heart disease, another for diabetes. We thought it didn't make sense since a lot of those conditions have the same risk factors like obesity and smoking. And now States will get one comprehensive grant that allows them more flexibility to address chronic disease in their home territories more effectively.

The 2012 budget we are releasing today makes tough choices and smart targeted investments today so we have a stronger, healthy and more competitive America tomorrow. That is what it will take to win the future and that is what we are determined to do. So thank you, Mr. Chairman. I will look forward to answering your questions.

[The prepared statement of Ms. Sebelius follows:]

Summary of Statement by Kathleen Sebelius, Secretary U.S. Department of Health and Human Services on The President's Fiscal Year 2012 Budget.

March 3, 2011 before the Committee on Energy and Commerce Subcommittee on Health

The 2012 budget is the blueprint for the President's vision of how the United States can win the future by out-educating, out-building and out-innovating the rest of the world. It will give every family and business the chance to thrive while making the investments that will grow our economy and create jobs.

This budget also recognizes that we can't build lasting prosperity on a mountain of debt. So in drafting this budget, we looked closely at every program in our department. When we found waste, we cut it. When programs weren't working well enough, we redesigned them to put a new focus on results. In some cases, we cut programs that we would not have cut in better fiscal times.

The budget supports innovative new models of health care that will improve patient safety and quality while reducing the burden of rising health costs on families, businesses, cities and states. It makes new investments in our health care workforce and community health centers.

At the same time, the budget includes additional proposals that will strengthen program integrity in Medicare, promote lower pharmaceutical costs and improve Medicare program operations, as well as savings proposals to strengthen Medicaid.

To make sure America continues to lead the world in innovation, our budget also increases funding for the National Institutes of Health. These new funds will allow the world's leading scientists to pursue breakthrough discoveries while keeping America at the forefront of biomedical research.

And because there's nothing more important to our future than the healthy development of our children, the budget includes significant increases in funding for child care and Head Start. But the budget does more than provide additional resources – it also aims to raise the bar on quality in child care and foster care programs and promote strong family relationships.

Because we have a responsibility to make every dollar count, the budget provides new support for President Obama's unprecedented push to stamp out waste, fraud, and abuse in our health care system – an effort that more than pays for itself, returning a record $4 billion to taxpayers in 2010 alone.

Over the last few months, we've also gone through our Department's budget, program by program, to find additional savings and opportunities where we can make our resources go further.

The 2012 budget we've released makes tough choices and smart, targeted investments today so that we can have a stronger, healthier, more competitive America tomorrow.

Mr. PITTS. Chair thanks the gentlelady and recognizes himself for 5 minutes for questions. Madame Secretary, Section 4002 of the PPACA created a fund to provide funding for programs authorized by the Public Health Service Act for prevention, wellness, and public health activities. From the period fiscal year 2012 to fiscal year 2021, there will be $17.75 billion deposited in fund. My question is who has the authority to determine how these funds are spent?

Ms. SEBELIUS. Mr. Chairman, our department in consultation with Congress we—presents a spending plan for the prevention fund a year at a time.

Mr. PITTS. Follow-up on that. Are you authorized to spend this money without any further Congressional action?

Ms. SEBELIUS. Yes, we are.

Mr. PITTS. Are you authorized to add funds to a program above and beyond what Congress appropriated for that program in a given year?

Ms. SEBELIUS. Yes, yes, sir.

Mr. PITTS. Madame Secretary, like most States nationally, my State is struggling with a major projected shortfall in its coming budget. The maintenance of effort provision in PPACA for the Medicaid program is removing a major lever for them to consider as they try to balance the budget. Can you give me a yes or no answer as to whether there will be an opportunity to waive that provision to help Pennsylvania and other States close their budget holes?

Ms. SEBELIUS. Mr. Chairman, the question doesn't lend itself to yes or no. We are—have the ability to grant 1115 waivers to States that improve the Medicaid Program and we are working very actively with Governors across the country. I have met with all the new Governors. We have been in 19 States so far. We are working a budget at a time to look at the flexibility that Governors are requesting.

Mr. PITTS. Given that the Supreme Court will be looking at this new law in the coming months or years, we as a Congress have to prepare for the possibility that a portion of PPACA might be invalidated while other parts remain. If the individual mandate were set aside and the remaining portions of the bill were left intact, what would be the impact in the total number of uninsured and assuming that number would grow would the administration seek to find a new way to cover these folks through Medicaid?

Ms. SEBELIUS. Well, Mr. Chairman, we are confident that the personal responsibility portion will be upheld. There are 12 judges who have dismissed cases so far: three Federal judges including one as recently as last week who have held the entire law constitutional; one Judge in Virginia who found a portion, the individual responsibility portion, unconstitutional, but declared it severable and refused to grant an injunction; and a Florida judge who has ruled another way. So our team is confident at the end of the day that the law will be held constitutional. We are looking at a variety of options and those were examined as the Affordable Care Act was being considered about the best way—if you eliminate preexisting conditions to make sure that you have a stable and secure insurance pool—as you know the personal responsibility section actually came from the insurance industry, from the American Association of Health Insurance Plans who felt that the way to have a solvent

pool in an insurance market is to make sure that you can balance the risk. And that proposal really comes from the insurance industry.

Mr. PITTS. If you could give me a yes or no—will you approve of Medicaid Block Grant Program?

Ms. SEBELIUS. Mr. Chairman, there isn't a block grant program that is being suggested at this point. But I know that there is some interest in that. I can't tell you what the parameters might be. I think a block grant has the real danger of shifting enormous burdens onto already strapped States.

Mr. PITTS. Thank you. I will yield the balance of my time to Dr. Cassidy.

Mr. CASSIDY. Thank you, Ms. Secretary. One of my concerns is how the State Medicaid budgets are going to be supplemented. Mr. Waxman the other day spoke about currently there appear to be discrepancies how much a State should get and how much they do get. Frankly, his State, California, suffers under this. It is important because Jonathan Gruber, I think one of your consultants published an article that says in his State about 1.7 million people will be added to Medicaid, so—under this plan—so it is going to stress it further. Do you see concerns with how the current FMAP, SMAP is constructed equity issues regarding States? I say that because Vermont, although a lower FMAP, gets about $7,500 permanent resident beneficiary and Mississippi gets—with a higher FMAP, about $3,000 per beneficiary. Any thoughts about that?

Ms. SEBELIUS. Well, I know there are constant concerns about the formula that is the allocation formula for FMAP. Mississippi actually has the highest match rate of any State.

Mr. CASSIDY. But they only get $3,000 from the Federal Government. So they have an 83 percent FMAP, but they only get $3,000 per beneficiary.

Ms. SEBELIUS. And I won't dispute that. I don't know the numbers. I do know they have the highest FMAP rate in the country. I think that there is a constant analysis of changing demographics, changing populations. I know in your State of Louisiana it became an issue after Katrina in New Orleans and the changing demographics of that city changed dramatically their share of the Federal budget. So there have been concerns over the past and we would work with Congress to look at updating the FMAP on a regular basis.

Mr. PITTS. My time is expired. Yield 5 minutes to the Ranking Member, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. I would mention to you that if you would entertain the possibility of upping F map or doing more with F map I would be glad to oblige. Just so you had any doubt about where I stand on that issue—would be more than willing to do another F map bill and increase the F map funding.

I wanted to ask about innovation, Madame Secretary. America's competitiveness depends on our ability to innovate and keep America number one but instead the Republicans included over a billion dollars in cuts to NIH and over 240 million to the Food and Drug Administration in their 2011 CR, and I believe this represents a significant setback because key agencies like NIH and FDA are essential to facilitating an environment where Americans can con-

tinue to innovate. For instance, at a medical device hearing last week we heard about CDRH's newly announced medical device innovation initiative and this is a new Voluntary Priority Review Program by FDA for new breakthrough medical devices to help innovator companies bring their products to market. But in the cuts, if the cuts in the Republican's CR are enacted, FDA did not think they would have the funds to implement this initiative. And this is just an example of the dangerous impacts we would see if FDA's budget is cut by over $240 million. So Madame Secretary, I believe a cut of 17 percent will slow the approvals for devices, drugs, and other innovative products, isn't that correct? I mean, isn't that what we are going to face with the FDA if this CR becomes law?

Ms. SEBELIUS. Well I think, Congressman, the President shares your belief that investments in both the Food and Drug Administration and in the National Institutes of Health are wise and strategic investments for the safety and security of our food supply, and our acceleration of devices and drugs getting to the market, and to keep America at the forefront of the biomedical industry which we have been for decades. So he has made recommendations about investments, enhancements to both the National Institutes of Health budget and for the Food and Drug Administration and believes strongly that that is really keeping a commitment with the—not only the American public, but growing jobs in the economy that we desperately need. And that the failure to fund those agencies to the full extent both jeopardize some of the important responsibilities they have as well as threaten—I think the last detail I saw from Dr. Collins at NIH is that for every dollar in research grants, seven dollars is generated in a local community. So that it has an enormous ripple effect when research grants are put out in university communities across this country as well as the life saving cure possibility that results.

Mr. PALLONE. And I mean, the same is true—I mean, the CR with the NIH, the CR proposes over a billion dollars in cuts to the NIH budget. For innovation the CR is worse. It appears the majority of the cuts will come out of the small percent of the budget for new NIH grants—about 640 million from the budget of 3.9 billion. That would mean thousands of fewer NIH awards this year. Again, I mean, the cut to the NIH would be devastating on the cutting-edge research into new cures and treatments for diseases. If you would just comment on that briefly, because then I do want to ask about the Children's Graduate Medical Education.

Ms. SEBELIUS. Well, as you know, Congressman, the NIH budget had a dramatic increase in funding thanks to the investment in the Recovery Act, feeling that scientific investment was a major innovation effort for the United States. So they are already struggling with that grant funding which is coming to an end. And I can tell you it will have a very chilling impact on research grants across this country if indeed the NIH budget is not adequately funded in 2012.

Mr. PALLONE. All right, let me ask you this about the Children's Graduate Medical Education because the President has budget zeroed that out. In my home State of New Jersey, we have the highest rate of autism in the country, one in 94 children. In my district, Children Specialized Hospital provides services to children with

disabilities and clinical services to like 4,000 kids. My concern is that you know we have very few subspecialties in pediatrics right now and in the budget, the President's budget, it basically justifies zeroing it out by saying that they want to focus on primary care. But we actually need more subspecialists, not you know more so by every, you know, physician's group. So how do you justify that? I mean, it seems to not make sense to me.

Ms. SEBELIUS. Well, I would say, Mr. Chairman, I—your concern about this program we have heard from a number of people and I can assure you in any different budget time this would not have been one of the recommendations. The goal was to try and focus as many GME dollars as possible into the work force for primary care, gerontology, and to put it into the programs where the vast majority is training primary care doctors. But this trade-off is very difficult.

Mr. PALLONE. OK. Thank you, Madame Secretary. Thank you, Mr. Chairman.

Mr. PITTS. Gentleman's time has expired. Recognizes the chairman of the full committee, Mr. Upton, for 5 minutes.

Mr. UPTON. Thank you, Mr. Chairman. I want to just start off initially by following up on a question that you asked regarding the maintenance of effort. Now, the President said earlier this week that if the States could present a bipartisan proposal on Medicaid that he would like to support it and if there is broad bipartisan support to repeal the maintenance of effort, would that be something that you would like to work with us on to see it happen?

Ms. SEBELIUS. Well, the President has directed me, Chairman Upton, to work with the Governors around this proposal, so I will be very actively involved. And he is eager to see their ideas. I think what we are eager to do and have pointed out to a number of Governors is the focus of the—a lot of the cost drivers is the so-called dual-eligible, which is why at—Congress was wise enough to include a new office of dual-eligibles as part of the Affordable Care Act structure. It is about 15 percent of the population of Medicaid beneficiaries and over close to 40 percent of the cost nationwide. So we are really eager to work on those issues.

Mr. UPTON. Now, I know that the President—this happened earlier this week so there has not been a lot of time, but have you identified a subset of Republican and Democratic Governors that will be the lead that you are going to work with yet?

Ms. SEBELIUS. That is not—believe me, I am very deferential to my former colleagues.

Mr. UPTON. I know you are.

Ms. SEBELIUS. The National Governors Association, Governor Gregoire chairs it and Governor Heineman from Nebraska is the vice chair this year. They have been asked to put together a Governor's group.

Mr. UPTON. OK. Let me ask you. In your testimony you discussed the State-based health insurance exchanges that were created by the new law. As noted in your budget you are provided a mandatory appropriation, not simply an authorization of such sums as necessary to issue grants to States. Is there any monetary limitations to the grant making authority?

Ms. SEBELIUS. No, sir.

Mr. UPTON. The——

Ms. SEBELIUS. With the exception that the exchanges have a series of legal parameters that have to be met in order to draw down funds.

Mr. UPTON. Under Section 1311H, it authorizes your department to force doctors, hospitals, and other providers to meet new quality requirements or face expulsion from contracting with any qualified health plans offered in the exchange. Has HHS started to draft any regulations yet on that—those provisions that you are aware of?

Ms. SEBELIUS. Mr. Chairman, I am not aware of any mandatory provider provisions or expulsion. I will be glad to answer that question in writing. I don't—I am not familiar with the section that you are speaking of off the top of my head——

Mr. UPTON. OK.

Ms. SEBELIUS. I am sorry.

Mr. UPTON. Before the House Budget Committee two weeks ago, I want to say a Richard Foster CMS was asked about two of the main claims that the supporters of PPACA talked about. First he was asked about whether the claim that the law would hold down cost—whether it was true or false. He said false more so than true. And second, he was asked whether Americans, whether they could keep their health care plans if they like them and he indicated that it was not true in all cases. So those are his words. Do you agree or disagree with some of the things that he said?

Ms. SEBELIUS. Mr. Chairman, I have read Mr. Foster's testimony and I think that what he has indicated is that he does not feel it is likely that Congress follow the outlines of the law. I—if indeed the law has changed there will be a different result. We believe the Congressional Budget Office analysis that—which was updated just I think 10 days ago—that $230 billion would be saved over the next 10 years and a trillion dollars over the two decades is an accurate assessment. If indeed the laws change there needs to be a different assessment.

Mr. UPTON. Last question I have is regarding the grandfather status on the healthcare plans. By some estimates provided in your department's rule anywhere between 87 million and 117 million Americans will not be able to keep their healthcare plan. Does the Administration continue to claim that the healthcare law will in fact allow their plan—allow Americans to keep their plan if they like it?

Ms. SEBELIUS. Mr. Chairman, the law is built around the private insurance market and as you know employers voluntarily enter that market and make decisions a year at a time on plan design, on provider issues, on network issues. The grandfather clause is designed to make sure that as much as possible, without shifting major financial burdens onto consumers or dramatically changing benefits, that plans can indeed keep exactly the plan moving forward, making adjustments in premiums as they go along. But nothing precludes what has been part of a dynamic market in the private sector all along which is that employers choose year in and year out, moving in and out of a marketplace.

Mr. PITTS. The gentleman's time has expired. Chair recognizes the Ranking Member of the Full Committee, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman. Madame Secretary, as I mentioned in my opening statement I am deeply concerned about the cuts proposed by the Republicans for the remaining seven months of this fiscal year and their continuing resolution H.R. 1. I have a letter, Mr. Chairman, I would like to insert in the record by unanimous consent from the Social Security Administration to its employees.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

NUC-2011-A01

Mr. James E. Marshall, Spokesperson
SSA/AFGE General Committee
P.O. Box 1698
Falls Church, VA 22041

Dear Mr. Marshall:

Pursuant to Article 4 of the National Agreement, this letter serves as notice to bargain over the impact and implementation of a furlough procedure in the event of an Agency furlough. It is important to note that the Commissioner has not decided to effectuate a furlough. However, given the potential of reduced Congressional appropriations for the remainder of the fiscal year, the Agency is issuing this notice at this time in the event that a furlough may become necessary.

Following receipt of a request to bargain, management is prepared to bargain over negotiable proposals concerning procedures and arrangements related to the aforementioned issue. Any bargaining will be in accordance with the Statute and Article 4 of the SSA/AFGE National Agreement. Accordingly, since this notice is being provided electronically, any bargaining must commence no later than the first Tuesday following the twenty-eighth (28) calendar day period after the receipt of this notice. In accordance with Article 4, Section 1(B), failure to request to bargain within the timeframes set out for national level bargaining may result in unilateral implementation.

Pursuant to Article 4, Section 3(C), please submit your reply to this notice by electronic correspondence to DCHR.OLMER.OAC@ssa.gov. Should you wish to discuss this matter please contact Eddie Taylor at (410) 965-7066.

Sincerely,

Jay Clary

Acting Associate Commissioner
Office of Labor-Management
and Employee Relations

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Mr. WAXMAN. This letter states that the Social Security Administration may have to initiate furloughs if the budget cuts being considered by the House become law. Why would that matter to Medicare, Madame Secretary?

Ms. SEBELIUS. That the Social Security Administration?

Mr. WAXMAN. Right, well the Social Security Administration processes the new enrollments into Medicare. Furloughs at the Social Security Administration would lead to backlogs in processing new enrollment and gaps in coverage for nearly half a million new Medicare beneficiaries. So that should be of concern not just for Social Security, but for the Medicare Program.

Ms. SEBELIUS. Well, and Mr. Waxman, as you know the first of the baby boomers became Medicare eligible so we are seeing an expanded Medicare beneficiary class this year and every year of the immediate future. So enrolling people in a timely and accurate fashion is hugely important.

Mr. WAXMAN. So that would really bop the baby boomers who are becoming Medicare——

Ms. SEBELIUS. 2011 is the first baby boomer Medicare-eligible class.

Mr. WAXMAN. Mr. Chairman, I have an analysis from the Democratic Staff that I would like to ask for unanimous consent to insert into the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

MEMORANDUM

March 2, 2011

To: **Democratic Members of the Energy and Commerce Committee, Subcommittee on Health**

Fr: **Democratic Staff**

Re: **Subcommittee Hearing Titled "FY 2012 HHS Budget and the Implementation of Public Laws 111-148 and 111-152"**

At 10:00 a.m. on Thursday, March 3, 2011, in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing titled "FY 2012 HHS Budget and the Implementation of Public Laws 111-148 and 111-152." The witness will be Kathleen Sebelius, Secretary of the Department of Health and Human Services.

I. BACKGROUND ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (HHS) is the Department primarily responsible for carrying out laws intended to improve the health of Americans. It operates as 8 U. S. Public Health Service programs and 3 human services agencies.[1] The Department's responsibilities range from ensuring the timely and accurate payment of claims for medical services for Medicare and Medicaid beneficiaries, to the inspection of pharmaceutical manufacturing plans to a safe drug supply for the country, to the promotion of advanced biomedical research in cancer and other deadly diseases, and other vital public safety and health functions.

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[1] U.S. Department of Health and Human Services, *About HHS* (online at http://www.hhs.gov/about/ (accessed March 2, 2011).

II. PRESIDENT'S BUDGET REQUEST FOR FISCAL YEAR 2012

The President's budget request for the 2012 fiscal year is consistent with his pledge to maintain an overall freeze on discretionary spending for the next five years. HHS would see a small decrease in total budget authority for discretionary programs, from $79.987 billion to $79.915 billion, comparing the requested 2012 amounts to the enacted 2010 amounts.[2] That aggregate change masks some important variation within programs, such as an increase in the budget for the Centers for Medicare & Medicaid Services reflecting its assumption of duties implementing health reform, and the proposed decrease in funding for the Public Health and Social Services Emergency Fund.

The majority of the HHS budget is concerned with funding health benefits for Medicare, Medicaid, Children's Health Insurance Program, and Indian Health Services beneficiaries and enrollees. The CMS budget request for 2012 is $777 billion. Out of that amount, just $5.4 billion would be used for program administration, claims processing, quality assurance activities, and efforts to control waste, fraud, and abuse. The remaining $772 billion is already made available by law to pay for the health needs of seniors, persons with disabilities, children, and other beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program.

III. PROPOSED BUDGET AND STAFFING LEVELS FOR HEALTH REFORM-RELATED ACTIVITIES

A. Budget for the Center for Consumer Information and Insurance Oversight

In 2010, Secretary Sebelius established the Office for Consumer Information and Insurance Oversight (OCIIO) to manage the early implementation of the Affordable Care Act (ACA; P.L. 111-148 and P.L. 111-152). The ACA appropriated $1 billion to begin implementation of its key protections including allowing young adults to stay on their parents' policies until age 26, requiring health insurers to maintain coverage for people even when they become sick, and requiring coverage of preventive services in new plans. That initial implementation appropriation funded OCIIO's operations for last year and this year along with operations in the rest of HHS, the Department of Treasury, and the Department of Labor.

At the beginning of this year, the Secretary of HHS announced her intention to move OCIIO to the Centers for Medicare & Medicaid Services (CMS) in order to

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[2] U.S. Department of Health and Human Services, "Budget in Brief", page 11, (online at http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf (accessed March 2, 2011).

minimize costs and streamline implementation. As part of that move the office was renamed as the Center for Consumer Information and Insurance Oversight (CCIIO). Accordingly, future budget requests for that center will be made through CMS.

For 2012, CMS is requesting an increase in its discretionary budget authority for program management to $4.4 billion (from $3.4 billion in 2010). That increase reflects several factors and is offset by reductions elsewhere in the HHS budget request.[3]

- $330 million is for the duties of CCIIO in implementing the ACA, including $236 million for grants to states to establish health insurance exchanges.[4]
- $50 million is for increased survey and certification frequency to improve the quality of care in Medicare and Medicaid.
- The remainder (approximately $590 million) is for increased claims workload in Medicare, increased systems and IT needs for administering all CMS programs, improvements in health plan oversight in Medicare, beneficiary and provider outreach in Medicaid and Medicare, and other programmatic needs.

CMS is also requesting a $270 million increase in discretionary fraud funding to fight fraud in Medicare and Medicaid.

For 2012, HHS is asking that CCIIO be staffed at 272 full-time equivalent employees, an amount that is less than ½ of 1% of the entire HHS staffing level today of 73,000 employees.

The ACA appropriated $1 billion to begin implementation of health reform. Of that amount, HHS projects that approximately $160 million will remain by the end of 2011. The President's budget places activities to implement the ACA in the context of the regular budget process in which the Congress can evaluate programmatic needs and make funding decisions through the appropriations process. A recent parallel is the implementation of the prescription drug benefit in Medicare following enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173). In that Act, Congress appropriated one-time amounts of $1.5 billion to fund the implementation of the prescription drug benefit and other changes to the Medicare program. Subsequent funding for administration of the prescription drug benefit was provided through the regular appropriations process.

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[3] U.S. Department of Health and Human Services, FY 2012, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees* (online at http://www.cms.gov/PerformanceBudget/Downloads/CMSFY12CJ.pdf) (accessed March 2, 2011).

[4] U.S. Department of Health and Human Services, "Budget in Brief", page 11, (online at http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf (accessed March 2, 2011).

B. Creation of the CCIIO and Transfer to CMS

The ACA confers broad authority on the Secretary of the Department of Health and Human Services to implement key provisions of healthcare reform, including creation and enforcement of new insurance market rules, compilation of information about insurance options, and dissemination of that information to consumers.

The Act's directives to the Secretary to create and enforce rules implementing its provisions, along with appropriation of funds to do so, provide the Secretary with authority to establish within the Department a single division dedicated to carrying out those congressional goals.[5] Secretary Sebelius created the Office of Consumer Information and Insurance Oversight (OCIIO) within the Office of the Secretary to meet that mission.

On January 5, 2010, Secretary Sebelius announced in a letter to House Appropriations Committee Chairman Harold Rogers that OCIIO would be moving out of the Office of the Secretary and into CMS and that OCIIO would be renamed the Center for Consumer Information and Insurance Oversight (CCIIO). According the Secretary, OCIIO's initial placement in the Office of the Secretary allowed senior leadership at HHS to manage early policy and program development and to ensure that expertise from across HHS was brought to bear on that development.

According to the Secretary, as the department moved from a development phase of healthcare reform to an implementation and operational phase, placement of OCIIO within an operating division of the Department would create organizational efficiencies, generate administrative savings, and allow CCIIO's staff greater access to the administrative expertise housed at CMS. CMS amended its section of the HHS Organizational Manual in the *Federal Register* to reflect this move on January 26, 2011, and the move and renaming became official in February. Jay Angoff, who had served as OCIIO's Director, remained in the Office of the Secretary as a senior adviser to the Secretary and Steve Larsen, who had directed OCIIO's Office of Oversight, took over as Director of CCIIO.[6]

IV. EFFECT OF THE HOUSE-PASSED H.R. 1, THE FULL-YEAR CONTINUING APPROPRIATIONS ACT

On February 19, at 4:40 a.m., the House of Representatives passed H.R. 1, the Full-Year Continuing Appropriations Act of 2011 (the CR). Among other provisions, the bill would reduce the amount appropriated for the Department of HHS by at least $8.5 billion. The enacted level for 2010 for HHS was $80 billion. With just 7 months left in the fiscal year governed by H.R. 1, the $8.5 billion in proposed cuts would amount to a funding cut for the entire department of 18% for the remaining 7 months of the year.

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[5] *See, e.g.*, 5 U.S.C. §§ 301, 302.
[6] *Id.*

The cuts proposed in H.R. 1 for selected agencies and programs are summarized below. Because only 7 months remain in the fiscal year, the proposed reductions in appropriated amounts are far more severe than they appear as a percent of the total agency budgets. For comparison, the amounts are shown as a percent of what the agencies received in 2010 and are using under the short-term continuing resolution they are operating under today.[7]

[7] Public Law No. 111 – 322, passed by Congress on December 21, 2010.

Summary of the effect of cuts in H.R. 1, Republican Continuing Resolution passed by the House on February 19, 2011

	2010 Discretionary budget authority[8]	7/12ths 2010 appropriation	H.R. 1 proposed cuts relative to 2010 enacted[9]	Proposed cuts as percent of 7/12ths of 2010 appropriation
CMS	$3,470	$2,024	$458	23%
FDA	$2,364	$1,379	$241	17%
NIH	$31,084	$18,132	$1,645	9%
CDC	$6,474	$3,777	$1,414	37%
HRSA	$7,483	$4,365	$2,132	49%
SAMHSA	$3,432	$2,002	$227	11%

Dollars in millions. CMS: Centers for Medicare & Medicaid Services; FDA: Food and Drug Administration; NIH: National Institutes of Health; CDC: Centers for Disease Control and Prevention; HRSA: Health Resources and Services Administration; SAMHSA: Substance Abuse and Mental Health Services Administration.

Source: Committee staff compilation based on HHS budget documents and discussion with staff of the Committee on Appropriations.

Note: The effect of the proposed funding reductions will depend on the nature of the agencies' work and the timing of the reduction. Grant-making activities like those at NIH would be affected differently from benefit administration duties like those at the Centers for Medicare & Medicaid Services.

Note: The $1.4 billion proposed reduction for CDC includes a $750 million reduction in the Prevention and Public Health fund created in the ACA.

Note: The $2.1 billion proposed cut for HRSA includes a $1 billion cut for Community Health Centers (CHCs), equal to the entire amount of increased funding for CHCs provided for under the ACA in this year.

C. Programmatic Impacts of Cuts in H.R. 1

[8] U.S. Department of Health and Human Services, "Budget in Brief", page 11, (online at http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf (accessed March 2, 2011).

[9] House Committee on Appropriations, *FY 2011 Continuing Resolution Reductions* (online at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf) (accessed March 2, 2011).

1. Reductions Proposed for CMS

The reduction proposed for the Centers for Medicare & Medicaid Services could have a serious impact on access to healthcare services for Medicare & Medicaid beneficiaries. Medicare process 1 billion claims for its beneficiaries each year. A reduction of the magnitude proposed by the continuing resolution could lead to several adverse results for beneficiaries and taxpayers:

a. Processing New Enrollees

Nearly half a million new Medicare beneficiaries would not be able to obtain care because they would be in an enrollment backlog for this year.[10] The Social Security Administration has notified its employees that it may have to institute furloughs under cuts like those proposed by the Republicans' CR in H.R. 1.[11] The Social Security Administration is responsible for processing the thousands of new applications for Medicare benefits received every day. Furloughs would lead to backlogs in processing new enrollment and delays in accessing needed services.

b. Medicare Claims Might Not Be Paid on Time

Today, Medicare is one of the most efficient and timeliest payers in any providers' practice, paying "clean" claims in 14 – 30 days. The reductions proposed in the CR could jeopardize payment of claims for services including inpatient hospital stays, physician visits, durable medical equipment, and other vital medical services.

Failure to pay providers for services they provide could lead to serious access problems for Medicare beneficiaries.

c. Program Oversight and Integrity Might Be Neglected

CMS is responsible for ensuring that payments are accurate and that the programs' safeguards against fraud are maintained and improved. The Affordable Care

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[10] House Committee on Ways & Means, Democratic Staff, *DOING THE MATH: Republicans use budget gimmickry to cover up Social Security Administration Cuts*, February 17, 2011 (online at http://democrats.waysandmeans.house.gov/press/PRArticle.aspx?NewsID=11470).

[11] [11] House Committee on Ways & Means, Democratic Staff, *BREAKING: Social Security Administration Warns of Furloughs*, February 18, 2011 (online at http://dems.waysandmeans.house.gov/press/PRArticle.aspx?NewsID=11472).

Act contained many provisions to help CMS prevent and detect fraud that are now being implemented. Reductions of the level proposed by the CR would impair CMS's ability to fight fraud in Medicare and Medicaid.

d. Quality and Safety Inspections Could be Neglected

The CMS budget includes funding for basic health and safety inspections, usually carried out by state inspectors. These inspections guarantee that facilities like nursing homes meet basic safety and quality requirements. CMS also administers basic conditions of participation to ensure that providers in the Medicare program are licensed and qualified to provide the services for which they are billing.

The CR's proposed reductions could jeopardize the ability of CMS to carry out and oversee these inspections and certifications, with dangerous results for beneficiaries.

e. Community Health Centers

The CR's proposed reductions would also threaten access to care for low-income people who rely on community health centers. Community health centers have historically have found bipartisan support. With the help of funding in the President's recovery package, these centers have expanded services during the economic recession and served 3.3 million new patients and added thousands of jobs to do so. The funding reduction proposed by the Republican's CR would close 127 health centers, cut off 11 million patients over the next year, and would force layoffs of thousands of employees.

2. Proposed Cuts to FDA

Because the Food and Drug Administration (FDA) regulates the safety of our foods, drugs, medical devices, and cosmetics, the cuts proposed in the CR for FDA could jeopardize the health of every American. FDA will lose resources that are critical to enabling the agency to conduct vital public health functions, such as:

- Rapidly identifying, assessing and responding to food-related health threats;
- Protecting patients from faulty or substandard and otherwise unsafe drugs, vaccines, devices and other medical products;
- Evaluating the safety and effectiveness of new vaccines against infectious disease, including diseases terrorists could use as bio weapons and keep vaccines stockpiled; and
- Protecting the nation's blood supply.

3. Proposed Public Health Cuts

Public health programs designed to find cures for diseases such as diabetes and cancer (programs at NIH) and to prevent illness and disability in the first place (programs at CDC) also would see substantial cuts in funding under the CR. Much of this work benefits those populations experiencing health disparities.

4. Appropriations Riders

In addition to the funding reductions proposed in the Republican's CR, the bill contains nine amendments intended to block implementation of all of, or components of, health reform.[12] If enacted, these amendments would bring implementation of the Affordable Care Act to a halt, eliminating benefits that people are already enjoying such as discounts on drugs in the donut hole in Medicare, free annual wellness visits in Medicare, the prohibition of rescissions among health insurers, the provision of preventive care without cost-sharing among enrollees in new plans, and other vital patient protections.

V. MEDICARE'S SUSTAINABLE GROWTH RATE PAYMENT SYSTEM FOR PHYSICIANS

Republicans have criticized the President's budget's proposals regarding the sustainable growth rate system for Medicare physician payments. Under current law, payments to physicians would be reduced by 28% on January 1, 2011.

The sustainable growth rate was instituted as a method to control spending on physician services in the Balanced Budget Act of 1997 (P.L. 105-33) by a Republican-led Congress and was implemented in 1998.[13] Only four years after its implementation it became apparent that its spending targets were likely to be unrealistic, as a payment reduction of 4.8% was applied in 2002. Congress overrode scheduled payment reductions in 2003 – 2006 without paying for the override or by increasing the size of the reductions in future years.

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[12] House Committee on Appropriations, *CR IS A "MONUMENTAL ACCOMPLISHMENT" FOR AMERICAN TAXPAYERS*, February 19, 2011 (online at http://appropriations.house.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=264&Month=2&Year=2011).

[13] Jim Hahn, Congressional Research Service, *Medicare Physician Payment Updates and the Sustainable Growth (SGR) System*, December 3, 2010.

In 2006, for payment year 2007, the Republican-controlled Congress began a new practice of dramatically increasing cuts under the SGR to pay for temporary SGR modifications, creating large payment "cliffs." Prior to passage of the 2006 legislation the SGR system had never, by statutory protections, produced a cliff in any one year exceeding 5.0%. After the 2006 legislation[14], planned cuts skyrocketed to 10.1% in 2008, 21% for 2010, and now 28% for 2012. Each of the planned cuts prior to this year has been overridden. In the case of legislation overriding cuts for 2008 – 2011, these overrides were paid for by reductions in spending by Democratic congresses.

The President's budget proposes two years of offsets to cover the costs of filling in the SGR gap for 2012 and 2013. Those offset proposals would provide $62 billion worth of offsets to cover $54 billion worth of SGR-related costs, in the budget's estimation.[15] The budget also maintains the President's previous commitment to filling in the SGR gap permanently, and proposes to work with Congress to offset future costs. CBO estimated in its January baseline that the cost through 2021 of filling in the SGR gap would be $250 billion, or 3% of projected Medicare outlays.[16]

VI. HHS RESPONSE TO COMMITTEE OVERSIGHT REQUESTS

The Republican memorandum to Committee members states that "the lack of HHS production of documents and responses since the February 16th Oversight and Investigations hearing on OCIIO is a potential issue for the Health Subcommittee hearing with Secretary Sebelius."[17] However, HHS been responsive to Committee requests and has produced over 50,000 documents, at significant expense, in response to the Committee's requests related to the waiver process and the creation of CCIIO.

VI. WITNESSES

Kathleen Sebelius, Secretary of the Department of Health and Human Services

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[14] The Tax Relief and Health Care Act of 2006 (TRHCA), P.L. No. 109-432.
[15] Office of Management and Budget, *Fiscal 2012 Budget*, Table S-8 (online at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/tables.pdf) (accessed March 2, 2011).
[16] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, pp. 61-62, (online at http://www.cbo.gov/ftpdocs/120xx/doc12039/01-26_FY2011Outlook.pdf).
[17] House Committee on Energy & Commerce, Republican Staff, *Internal Memorandum*, March 1, 2011.

Mr. WAXMAN. This memo documents the size of the cuts proposed by the Republicans—funding for CMS, the agency that runs the Medicare, Medicaid, and the Children's Health Insurance Program by 23 percent once you consider the fact that the year is almost halfway finished. This is not a little haircut or matter of finding some efficiencies. That kind of a cut could prevent CMS from performing its core duties, paying for the healthcare needs of seniors, persons with disabilities, mothers, and kids in Medicare, Medicaid, and CHIP. Madame Secretary, would you be concerned about the impact on Medicare beneficiaries of a proposed 23 percent cut combined with delays in processing the new enrollments?

Ms. SEBELIUS. Mr. Chair—I mean, yes, Congressman. It would be very difficult to continue the services to the American people. As you know, the administrative costs for Medicare in the budget year 2010 included no Affordable Care Act implementation because there was no Affordable Care Act. So what we are talking about is an enormous reduction in the overall ability to administer Medicare, Medicaid, the Children's Insurance Program at a time when there are significantly more beneficiaries in each of those programs around the country.

Mr. WAXMAN. And it is not limited to CMS across your department. Vital public health, vital public safety functions would be jeopardized. For instance, FDA would be cut and face an effective cut of 17 percent for the remainder of this year. Wouldn't this be a cut of that—wouldn't a cut of this magnitude seriously undermine FDA's responsibilities to rapidly identify and respond to food related health threats and its mission to protect patients from faulty or substandard drugs or devices?

Ms. SEBELIUS. Well Congressman, the President has recommended about a 31 percent increase in the Food and Drug Administration because of the new responsibilities with the Historic Food Safety Act and public initiatives.

Mr. WAXMAN. But he didn't anticipate this kind of a cut in this year. He was proposing more——

Ms. SEBELIUS. No, sir.

Mr. WAXMAN [continuing]. Money for next year. The Republicans are proposing to cut a billion dollars in funding to the community health centers as part of a shocking nearly 50 percent reduction for programs administered by the Health Resources and Services Administration, HRSA. That cut to health centers could result in the closure—no, would result in the closure of 127 health centers and countless layoffs. Wouldn't that jeopardize access to patient care?

Ms. SEBELIUS. Well, community health centers have long been a bipartisan effort to build a public health infrastructure delivering low-cost, high-quality preventive care around the country, and that would seriously impact people's health services.

Mr. WAXMAN. And for my last question about Medicaid, every State has a different Medicaid Program. There is flexibility already in that program. At Tuesday's hearing Governor Barbour and Herbert asserted the need for total flexibility. Governor Barbour said the problem is Federal regulations don't allow for—allow a provider to deny services to an individual on the basis of the individual's ability to pay. In addition, no cost sharing measures can be imposed on many Medicaid enrollees including children. Madame Sec-

retary, can you talk about the flexibility that is already in the system and how that is balanced against the minimal levels of beneficiary and provider protections with regard to cost sharing access to providers and more?

Ms. SEBELIUS. The Medicaid Program as you say is a Federal/State partnership and the program does look different in States around the country. The program already has enormous flexibility in the Affordable Care Act gives even more significant flexibility designing benefit packages, designing for some of the upper income beneficiaries cost sharing, making sure that optional services in some States are part of the package and other States they are not. So there is a wide variety of program designs. Some are entirely in managed care. Others are not. We are working actively—as you know, the Nation has a host of brand-new Governors and working actively with each of those States to not only give them a snapshot of what their program looks like but also the strategies that have been implemented in other parts of the country that have been very effective in delivering care and saving costs.

Mr. PITTS. Thank you. The gentleman's time is expired and will yield 5 minutes to the vice chairman of the committee, Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. And I don't want to take up too much time, but I would just point out to the Ranking Member of the Full Committee that the Democrats did have an entire year with which to come up with their budget and their appropriations. And it is only because they failed to do their work that we are doing the CR right now. Let me direct your attention once again——

Mr. PALLONE. The House asked that the Senate and public had stopped it——

Mr. BURGESS. I know Chairman gets—the time—reclaiming my time. Chairman Pitts referenced Judge Vinson's ruling in Florida from earlier in February and I sent you a letter on February 10 asking you about the implementation plans of HHS to which I have not yet received an answer. My concern is Judge Vinson in his ruling said that a declaratory judgment is the functional equivalent of an injunction and he went on to say that officials of the executive branch will adhere to the law as declared by the court.

As a result the declaratory judgment is a functionally equivalent—a declaratory judgment is the functional equivalent of an injunction. There is no reason to conclude that this presumption should not apply here. You apparently feel differently and we heard from our Governors earlier this week that they are in fact feel like they are on—I think Governor Herbert said shifting sands. You feel that ultimately the individual mandate will be upheld as constitutional by the Supreme Court. Judge Vinson felt otherwise. We are in a period where I wish we could accelerate or expedite the Supreme Court, but apparently I don't get my wish.

The Supreme Court will likely rule in June 2012 and that is a long time for the States to look at this and wonder which direction do we go. You could certainly provide some guidance and some help by saying you know we are going to look seriously at what Dr.—at what Judge Vinson said. So I still await a response from your letter but could you briefly give me some comfort that you are going to comply with the judge's order?

Ms. SEBELIUS. Congressman, I think it is far from clear what Judge Vinson's order indicates, so the Justice Department has gone back to the judge to ask him for a clarification of his order that——

Mr. BURGESS. Yes, reclaiming my time. Again, I think he stated it as clearly as he could. He is going to restate that and I look forward to his decision as well. But honestly, the decision of a member of the executive branch not to adhere to the directive of the court is—I think troubling.

Ms. SEBELIUS. He did not file an injunction, as you know, which is the standard procedure if we have asked him——

Mr. BURGESS. But attorneys——

Ms. SEBELIUS [continuing]. To clarify and look forward to his——

Mr. BURGESS. But Governors all across this country right now including my State of Texas and I know Attorney General Greg Abbott is very concerned about what do—you know, what do we do now because we don't know. Let me——

Ms. SEBELIUS. But there isn't anything now that is being done with the individual responsibility portion.

Mr. BURGESS. Well, I look forward to your written response to the letter I sent you a month ago and I hope that you will provide that for us.

Ms. SEBELIUS. We will.

Mr. BURGESS. We heard some of the questions have already centered around some of the issues of mandatory funding within the law that was signed last year and I am particularly concerned about Section 4101 both A and B. 4101A provides mandatory spending for the construction and only the construction of school clinics. 4101B creates new discretionary funding for paying the doctor and nurses who are going to work in those school clinics. So I guess the question is why is the construction mandatory and paying the staff discretionary?

Ms. SEBELIUS. That is the way the bill was constructed by members of Congress.

Mr. BURGESS. By members of the Senate Finance Committee Staff. And to take up where Chairman Upton was talking just a moment ago I would draw your attention in the law to Section 1311. It is on page 79, 78 of my copy of the law where under Enhancing Patient Safety beginning on January 1, 2015, a qualified health plan may contract with part B, a healthcare provider only if such provider implements such mechanisms to improve healthcare quality as the Secretary may by regulation require. I mean that is pretty specific, too. So where are you going with this? What have you directed your staff to look at? I mean again, providers all over the country are asking me what does this mean for us. Well, again, perhaps I could get that response in writing.

Ms. SEBELIUS. I am——

Mr. BURGESS. But you know I think—look, we switched sides here in January and the reason we switched sides was because of this law. It is precisely because of this type of language in this law that the American people looked at this and rejected the notion of what was forced upon them last year. There is unprecedented power now that goes to your office, unprecedented spending that goes to your office. These are decisions that are made exclusively by the Secretary of Health and Human Services. At no other time

in our history has so much power gone to one Federal agency. Can you understand why the American people are understandably concerned by what has happened to them?

Ms. SEBELIUS. Congressman, I think that the American public should be alarmed if we are paying taxpayer dollars to any provider or a hospital bed of over 50 which doesn't have a quality system in play. I——

Mr. BURGESS. But quality determined by the Secretary. Quality determined by the Secretary and no other—no right of appeal, no secondary motion may be made—only by the Secretary. That is what is affecting——

Ms. SEBELIUS. It would be in the CMS guidelines in terms of payments for Medicare, payments that, when that rule is promulgated, there will be plenty of public input. But again, I think it would be alarming if we paid taxpayer dollars without the quality measurement.

Mr. BURGESS. May I just add, the 10 rules have gone without public comment. Ten rules have gone into action.

Mr. PITTS. Gentleman's time is expired. Yield 5 minutes to the Ranking Member Emeritus, Mr. Dingell.

Mr. DINGELL. Thank you for you courtesy. Welcome Madame Secretary. It is a pleasure to see you here.

Ms. SEBELIUS. Sir.

Mr. DINGELL. Your old dad who served on this committee with me and worked in this room would be very proud of what you are doing. Thank you. Questions with regard to the Affordable Care Act, the continuing resolution H.R. 1 makes a number of blunt, reckless cuts in programs that are critical to the health and wellbeing of the American people. At the same time, the Affordable Care Act has begun implementing historic consumer protections including insuring coverage for children with pre-existing conditions, prohibiting rescissions on coverage by insurance companies, allowing children up to 26 to stay on their parents' insurance, amongst others. Under H.R. 1, CMS would receive a cut of 458 million or more than 23 percent of that agency's 2010 budget. Will H.R. 1 delay or impede the implementation of the consumer protection provisions of the health reform act, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Madame Secretary, would you please give us for the record a statement as to how and where these cuts will come and what will be the affect on the programs involved? Madame Secretary, the Affordable Care Act provides seniors on Medicare with a 50 percent discount on brand name drugs, a critical step towards increasing the coverage under Medicare Part D. Will H.R. 1 delay or prevent the seniors from receiving this discount, yes or no?

Ms. SEBELIUS. Mr. Chairman, the cuts to Medicare services will——

Mr. DINGELL. But it is a danger?

Ms. SEBELIUS. Pardon me?

Mr. DINGELL. But it is a danger that it will affect those provisions?

Ms. SEBELIUS. Yes, sir, yes sir.

Mr. DINGELL. All right, Madame Secretary, just yesterday we heard from Medicare Program Integrity Group Director John Spie-

gel regarding the anti-fraud efforts at CMS including the new tools provided by ACA to prevent fraud before it occurs. Will H.R. 1 delay or harm efforts to prevent fraud, waste, and abuse in Medicaid or Medicare, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Would you submit for the record a statement as to how and why?

Ms. SEBELIUS. I will.

Mr. DINGELL. Madame Secretary, with regard to food safety as you know another important undertaking is the implementation of FDA Food Safety Modernization Act. This legislation made historic investments in our food safety system and provided new authorities to help FDA to prevent food safety programs before they occur throughout the food supply. H.R. 1 included $241 million in cuts from the FDA. Will this cut or these cuts impede FDA's ability to implement the Food Safety Modernization Act, yes or no?

Ms. SEBELIUS. Yes, sir, they will.

Mr. DINGELL. Would you please explain that for the record if you please, Madame Secretary?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Madame Secretary, last Congress I enjoined with my colleagues Mr. Waxman, Mr. Pallone, and Mr. Stupak to introduce drug safety legislation that would give the FDA the authorities and resources it needs to adequately protect consumers from unsafe drugs and to monitor our food safety or rather the safety of our drug supply. Will H.R. 1 impede FDA center for drug evaluation and research from evaluating and monitoring drugs for safety and effectiveness, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Madame would you submit an explanation as to why that is so? Madame Secretary, the FDA is consistently and chronically underfunded and I continue to hope that FDA will get needed registration fees to help fully implement the food safety law. I note that those fees would have—were approved by and supported by the industry. Do you believe that registration fees are necessary to implementing the Food Safety Modernization Act, yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. Madame Secretary, you have been requested or the department has been requested to produce documents of the benefit of this committee. I would note Madame Secretary that HHS has produced over 50,000 documents I note a significant expense in response to the committee's requests related to the waiver process and the creation of CCIO. Would you submit to the statement or rather submit to the committee a statement as to how you have complied with that request for papers and documents and what seem to be the problems if any that exist with regard to the committee's requests for information?

Ms. SEBELIUS. I would be happy to submit that.

Mr. DINGELL. Madame Secretary, we have completed our business with 11 seconds. Thank you. Thank you.

Mr. PITTS. The gentleman's time is expired and Chair recognizes chair emeritus of the committee, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. Welcome, Secretary—Madame Secretary. Congratulations to your Jayhawks for beating my Texas Aggies last night in basketball. I hated to see it, but you all were the better team.

I think Dr. Burgess asked this question, but I am going to—I may ask it in a little bit different way. I think you are very well aware that a Federal court has recently ruled that the healthcare law that became law last year is unconstitutional. As the Chief Administrative Executive in charge of implementing that law what is your position on agreeing to the court order and ceasing to implement the new law? Do you intend to agree with it? Are you going to ignore it? Or are you going to appeal it? Could you enlighten us as to what your position is on this recent court ruling?

Ms. SEBELIUS. Well, Congressman Barton, thank you on behalf of the Hawks. We have sought a clarification from Judge Vinson about the implication both for the plaintiff States as well as the membership of the NFIB which is one of the plaintiffs in the Florida case. Once we get that clarification we intend then to take next steps. In the meantime we are actively implementing the law because, as you know, Judge Vinson is now an outlier in terms of what the other Federal judges—the four other judges who have ruled, have ruled very differently than the judge. So we are seeking clarification and continuing to move ahead.

Mr. BARTON. What is your timeline on that?

Ms. SEBELIUS. Well, the plaintiffs and the—we expect to hear back from the judge soon. The DOJ has filed their clarification request. The plaintiffs have responded this week, and the judge indicated that he would rule very quickly.

Mr. BARTON. Is it once that information is received from the judge is—whose decision is it? Is it your decision? Is it the Attorney General's decision? Is it the President's decision or all of the above on how to proceed?

Ms. SEBELIUS. Well, our legal team is led by the Department of Justice so we defer to their legal counsel.

Mr. BARTON. Do you have official input into the decision? In other words——

Ms. SEBELIUS. Into the legal counsel's decision?

Mr. BARTON. Well, you are the Secretary of Health and Human Services.

Ms. SEBELIUS. I understand. I—our legal counsel is involved with the justice team, but they are proceeding to have this dialogue with the court.

Mr. BARTON. OK. I would disagree with you that the judge's decision was an outlier. My understanding is that if you are keeping score it is 2 to 2. So I don't——

Ms. SEBELIUS. No, it is 3 to 2.

Mr. BARTON. We had—have we had another one?

Ms. SEBELIUS. I have to keep an accurate score and as I say there are 12 who have dismissed the case outright, so.

Mr. BARTON. All right.

Ms. SEBELIUS. And Congressman, the clarification I would make is that in the other decision which came out of a court in Virginia where the judge found an individual responsibility to be the one portion of the law that he found unconstitutional, he disagreed

with Judge Vinson's description that it was essential to strike down the entire law and so that is what I meant——

Mr. BARTON. Yes, I am aware of that.

Ms. SEBELIUS [continuing]. In terms of the outlier.

Mr. BARTON. And I guess one more—one last question on that. Is it conceivable that the Obama administration would appeal directly if the decision is to appeal—would appeal directly to the Supreme Court so that we get this thing solved hopefully before the next presidential election?

Ms. SEBELIUS. Congressman, the Attorney General of the State of Virginia has filed an expedited appeal to the United States Supreme Court asking them to grant cert in the case in Virginia. The Administration has opposed that decision to expedite, but that is now before the court. So that is ripe and the court will make a decision on whether or not they intend to expedite this case.

Mr. BARTON. My time has just about expired. I have got a number of questions for the record I will submit in writing. My final question is on NIH. Several years ago we passed an NIH Reform bill through this committee that was signed into law. That bill was a reauthorization bill. It lapsed several years ago and it is up for renewal. I am going to encourage Chairman Upton to have a hearing and hopefully do a reauthorization on that later this year or next year, but in that was the creation of a Common Fund to try to get more cross-semination, insemination between the various NIH organizations. Have you followed that? And if so, could you give us an update on how you believe that common fund is operating?

Ms. SEBELIUS. Well, Mr. Chairman, I know that the new director of the National Institutes of Health has taken a great interest in the Common Fund and has actively involved in not only seeking to fill gaps in research but directing it to the most promising options he feels in the research field. So I think it has been something that has been definitely a stream of funding that has been very important and one that I would be happy to get some detail from Dr. Collins on exactly where those funds are being directed. But it is something that he takes very seriously.

Mr. BARTON. Thank you, Madame Secretary. And thank you.

Mr. PITTS. Gentleman's time is expired. Chair yields 5 minutes to the gentleman from New York, Mr. Engel, for questions.

Mr. ENGEL. Well, thank you. Thank you, Mr. Chairman. You know I have been listening to the whining and complaining on the other side of the aisle and it just really boggles my mind, Madame Secretary. But the bottom line is do we want to provide American citizens with healthcare or don't we? I know there hasn't been any enthusiasm for the Affordable Care Act on the other side of the aisle, but you know let us try to improve it rather than try to destroy it.

I noted with a bit of a chuckle the assault on the Massachusetts law. The fact is that the Governor of Massachusetts came here and said that the law is working and I wonder if Governor Romney is going to run on his strong implementation of that law in the Republican primaries when he runs for president. Madame Secretary, what are the most dangerous things in the Republican cuts as you see it from your very important point of view of providing

healthcare for Americans and all the other things that are in the Republican plans for funding the Government? What do you see as the most draconian of the cuts and how would it affect the health of the American people?

Ms. SEBELIUS. Congressman, the President feels strongly that education, innovation, building are key blocks for the future. So the investment in early childhood education, which pays huge dividends down the road; the investment into scientific research to keep us at the front of biomedical innovation; the infrastructure for public health delivery with community health centers; and funding the training of providers—all of those are jeopardized without, you know, having adequate funding in the future as well as essential services. The centers for Medicare and Medicaid and—are looking at increased beneficiaries in a very restrictive budget and our efforts to have new fraud, waste, and abuse efforts which are really paying off are very much in jeopardy.

Mr. ENGEL. You know what I see in terms of the Republican for funding the Government, it is not a matter of the fact that we need to cut to balance a budget. We do need to balance our budget and I find it odd that we are giving these huge tax breaks to wealthy people and that blows a hole in the budget. And I find that very interesting, but it is an attempt as I can see it to get rid of all the programs Republicans having liked for all these years and to try to tie it in and kind of use the budget problems to do that. You know we see it on a State level in Wisconsin. We see it all over the country. And we see it on a national level as well. We had Governor Barbour here and he complained that he didn't like the Affordable Care Act and he would agree to block a grant. Do you think the people of Mississippi would be better off four years from now under Governor Barbour's blocked grant program or under the Affordable Care Act?

Ms. SEBELIUS. Congressman, I don't know a lot of the details about the Mississippi healthcare situation. I do know that they have a population that, by poverty level, qualifies them for the highest FMAP rate. And one of the challenges of any kind of block grant is if you would look at the recent economic downturn when millions more Americans qualified for Medicaid because they lost their jobs or their incomes took a drastic downturn. No State would have any help from the Federal Government in responding to that. It shifts huge burdens frankly onto State bases and doesn't have a Federal partnership moving forward.

Mr. ENGEL. Let me ask you this. There have been a number of criticisms of the Pre-existing Condition Insurance Program and I would like to just review the facts. First there was concern over whether there won't be enough money for all the people that will enroll. Then we heard that very few have enrolled and both criticisms were asserted as failures. How many people have enrolled and what changes have you made to the program in response? And let me throw out another question tying in with this. Governor Barbour at Tuesday's hearing asserted they were unable to run the program. So were States given the opportunity to run the program? Could they have run it in combination with existing high risk pools in the States? And the irony as I see it is that a high risk pool was essentially a tattered feature in the Republican proposal for health

reform debated right in this very committee last year. So I wonder if you can comment on those things.

Ms. SEBELIUS. Well, there are now approximately 12,000 people across this country who are enrolled in their State or the Federal high risk pool and the enrollment increased by about 50 percent over the last couple of months. Many States are—finally got their program set up, are doing aggressive outreach, are informing people but as you know there are some pretty strict requirements. You have to be uninsured for six months which is a barrier to a lot of folks. And the insurance, even though it is capped at market rates is still not inexpensive coverage. This was always designed as a bridge strategy to try and get to 2014 when the market rules will change and for the first time ever in the history of this country we will have insurance available without regard to people's pre-existing health condition. They will be able to participate in a broad based pool.

Mr. PITTS. Gentleman's time has expired. Chair recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. Madame Secretary, welcome. We have been waiting to visit with you for a long time. I would just—I would state that you know it is funny that you mention that NFIB which is a National Federation of Independent Businessmen were plaintiffs. When I thought they got such great small business tax credits that I wouldn't really expect them to be in opposition to this law. I—it is just I am surprised to hear that. The other thing—you were a Governor of a State and I would imagine that had you been governing—did you ever pass—under governorship was budgets passed? Did you pass budgets when you were Governor?

Ms. SEBELIUS. Yes, sir.

Mr. SHIMKUS. Was the chambers held by just Democrats in the Senate and the House or did you have——

Ms. SEBELIUS. Never.

Mr. SHIMKUS. What is that?

Ms. SEBELIUS. Never.

Mr. SHIMKUS. Never. And you passed budgets?

Ms. SEBELIUS. We did.

Mr. SHIMKUS. And then the last Congress we held—Democrats held the House of Representatives. That is true, right?

Ms. SEBELIUS. And the house passed a budget.

Mr. SHIMKUS. And they also held the Senate.

Ms. SEBELIUS. They did.

Mr. SHIMKUS. And we have a Democratic President?

Ms. SEBELIUS. Yes, we do.

Mr. SHIMKUS. And we didn't pass a budget?

Ms. SEBELIUS. I think the House passed a budget.

Mr. SHIMKUS. So I am—I guess I am trying to be a little cute. The point is the Democratic attack on this CR is because of their failure to pass a budget. So they can position all they want, you know we are in the majority because they can't pass a budget.

Mr. PALLONE. Will the gentleman yield?

Mr. SHIMKUS. No, I will not. We are in the majority because they passed this bill—became a law. We are in the majority because they passed Cap and Trade. Our frustration is the last time you

visited this committee was February 4, 2010, the last time. This bill was not even the law of the land. I became Ranking Member of the Health Subcommittee. After that vote Nathan Deal left and I think I asked the then-Chairmen Waxman and Frank Pallone who really is a great friend 19 times to ask you to come visit us. You never came. Why? Why didn't you come after the law to help us understand the provisions and the implementation of this law?

Ms. SEBELIUS. Congressman, I responded to the request that I got.

Mr. SHIMKUS. So you are saying we never requested you to come back?

Ms. SEBELIUS. Yes, sir.

Mr. SHIMKUS. OK. So Chairman Waxman did not ask you to come back to help explain this law?

Mr. PALLONE. Would the gentleman yield?

Mr. SHIMKUS. No, I will not.

Mr. PALLONE. He is referencing the Chair and it is not accurate.

Mr. SHIMKUS. No, I will not. I will not. Will you answer the question, Madame Secretary? Chairman Waxman never asked you——

Ms. SEBELIUS. Congressman, I will go back. I need to look at the record.

Mr. SHIMKUS. OK.

Ms. SEBELIUS. All I can tell you is I respond to the——

Mr. SHIMKUS. Will you submit the answer for the record in writing?

Ms. SEBELIUS. I will be happy to.

Mr. SHIMKUS. Thank you very much. Let me go—this is really a budget—our frustration is there are so many particular problems and concerns we haven't had a chance to really talk to you. This is a budget hearing so let us talk about a budget issue. In that February 4, 2010, hearing I asked you a question; it was kind of out of the same way. And then you admitted that the $500 billion Medicare cuts, there were $500 billion in Medicare cuts. Is that correct?

Ms. SEBELIUS. No, sir, it is not correct. There were $500 billion in a slowdown in growth rate spending.

Mr. SHIMKUS. Well, I would refer—I am reclaiming my time. I would refer you to the transcript.

Ms. SEBELIUS. Sir.

Mr. SHIMKUS. And I will read it if you want me to.

Ms. SEBELIUS. The growth rate was projected in Medicare to be at 8 percent.

Mr. SHIMKUS. "Mr. Shimkus: So the President supports cutting $500 billion in Medicare, yes or no? Secretary Sebelius: The President is supportive of the health reform legislation. Is that a yes? Secretary Sebelius: I said yes, sir." So our problem in this whole debate on Medicare cuts——

Ms. SEBELIUS. The health legislation doesn't include $500 million worth of cuts.

Mr. SHIMKUS. Ma'am, my concern—this is a budget hearing, so there is a—there is an issue here on the budget because your own actuary has said you can't double count. You can't count 500—they are attacking Medicare on the CR when their bill, your law cut $500 billion in Medicare. Then you are also using the same $500

billion to what? Say you are funding healthcare. Your own actuary says you can't do both. So my simple question—I have 26 seconds left. What is the $500 billion cuts for: preserving Medicare or funding healthcare law? Which is it?

Ms. SEBELIUS. Sir, the Affordable Care Act adds 12 years to the Medicare Trust Fund according to every actuary and the $500 billion represents a slowdown in the growth rate of Medicare over 10 years from what was projected at 8 percent to a growth rate of six——

Mr. SHIMKUS. So is it Medicare? Is he using it to save Medicare or are you using it to fund healthcare reform? Which one?

Ms. SEBELIUS. Both.

Mr. SHIMKUS. So you are double counting. I yield back my time.

Mr. PITTS. Gentleman's time is expired. Chair recognizes gentlelady from California, Mrs. Capps, for 5 minutes of questions.

Mrs. CAPPS. I am pleased to yield 10 seconds to the ranking member of the subcommittee.

Mr. PALLONE. I just wanted to say, Mr. Shimkus, you shouldn't be asking the Secretary about whether we invited her. Fact of the matter is that Mr. Waxman and myself did not invite her after the healthcare bill passed. And you can simply address that to us and the answer is no, we didn't invite her. So it is not that she failed to come, we did not invite her.

Ms. SEBELIUS. Thank you.

Mrs. CAPPS. Thank you, Mr. Pallone. Thank you for your testimony, Madame Secretary, and welcome to our subcommittee. I want to acknowledge and support the interest that was expressed by former Chairman Barton in the Common Fund he was describing and you answered how much the current Secretary of NIH or Chairman of NIH is supporting it as well. It was his idea and he got it funded in 2006 and point out to my colleagues that H.R. 1, the continuing resolution, cuts $48.5 million from the Common Fund. You know, these are tight fiscal times and I think the President's budget identifies areas for smart investments that will pay off both in improvements in the Nation's health and economic stability. The President has called on our Nation to come together to out-educate, out-innovate, and out-build our competitors. I support this focus and I think the HHS is in a strong position to help reach these goals. As nurse, I am concerned about strengthening the health work force. We face a primary care shortage now and as we move into implementation of health reform we are going to need an even more robust healthcare workforce. As you know, the Affordable Care Act lays out a course for creating that workforce, creating a commission to help guide analysis and recommendations of workforce enhancement, providing primary care providers a pay increase through both Medicare and Medicaid and providing enough service—enough funding to more than triple the National Health Service Corp. But we in Congress need to support these programs for proper implementation. So I am very concerned that the House continued resolution would cut workforce programs by about $145 million from the fiscal year 2010 level, slashing vital Title VII and Title VIII by nearly a third. I am particularly worried about Title VIII programs which support the education and training of nurses. We have a nursing shortage. Last year over 50,000 qualified appli-

cants were turned away from nursing schools due to budget constraints and the lack of faculty to train them. Madame Secretary, you understand this. The President's budget provided an increase in these same programs. Can you discuss the steps taken in the budget to strengthen our healthcare workforce and increase the numbers of jobs which will result from that?

Ms. SEBELIUS. Well, Congresswoman, I think that there is no doubt that the President shares your concern about the health workforce of the future which is why he has made it a focus each year in his budget and why I think the Affordable Care Act also focused on workforce enhancements. So the budget would include support as you say to train about 10,600 National Health Service Corp providers; train an addition 4,000 new primary care providers over the next five years. The Prevention and Public Health Fund Allocation would also increase the number of nurse practitioners. Six hundred nurse practitioners would be trained. Six hundred new physician assistants across the country would be available with the establishment of new community health centers there would be providers available in the most underserved areas, so there are a whole series of workforce enhancements that would be jeopardized either by defunding the Affordable Care Act or not passing the recommended President's budget.

Mrs. CAPPS. And what concerns me is it the House Continuing Resolution would be a reduction of 54 percent cutting our workforce programs by more than half in all of the areas that you specified. I think this is going to devastate our healthcare workforce. And I hope you will quickly agree with me.

Ms. SEBELIUS. Yes.

Mrs. CAPPS. Thank you. I needed that for the record. What puzzles me is that I know my colleagues across the aisle have expressed concerns that we don't have enough healthcare workforce, but I shared their concern and this—the key to addressing this problem is right in front of us and yet they propose cuts that will make the situation worse. Their budget will hamper efforts to fill the gaps that we have today and just as the demand for healthcare professionals increases. In my last minute, I would like to address something you mentioned in your remarks which are the $4 billion in waste, fraud, and abuse that HHS and the Department of Justice has recovered just in this past year—$4 billion that was saved for American taxpayers. When I am home meeting with my seniors in healthcare advocates as well about how they can be active participants now in looking for waste, fraud, and abuse. We want this to continue. Some of it is in the Medicare payments. Would you expand upon this $4 billion in savings and ways that we can look to increase this amount over the future?

Ms. SEBELIUS. Well, the President's budget again has requested additional resources. This is an enormous payoff——

Mrs. CAPPS. Yes.

Ms. SEBELIUS [continuing]. In terms of dollars returned for dollars spent. We are building new data systems that can allow us to spot billing irregularities in a much more timely fashion, recredentialling providers, putting in place strike forces. We would like to expand those strike forces which have been enormously helpful in the fraud hotspots. But this collaborative effort with not

only our partners at Justice, but local Attorneys General and States has been enormously effective so far and we hope to be able to expand and broaden that outreach.

Mrs. CAPPS. Thank you.

Mr. PITTS. Gentlelady's time is expired. Chair recognizes the gentleman from Pennsylvania, Mr.—Dr. Murphy for 5 minutes for questions.

Mr. MURPHY. Thank you. And thank you, Madame Secretary. Three things I think I am going to put out that we agree on. First of all that first Pitt and Kansas both deserve to be in the final four. A yes would be good. I will take that as a yes.

Ms. SEBELIUS. Yes.

Mr. MURPHY. Thanks. Number two, this committee worked very hard together and my friend and colleague Gene Green and I worked together on and it passed the House 417 to one a bill to allow doctors to volunteer at community health centers. Now, I know the estimates are that huge numbers of more people will go to community health centers. With the CBO analysis of this however just said that using the Federal Torts Claim Act and using only those numbers because that is all they are allowed to look at, I think the cost over several years was 30 million. But I am asking if your department could work with us in coming up with a more detailed analysis if we allowed the doctors to volunteer at community health centers what would the cost savings be in terms of allowing more patients to go through those centers. Is that something that you could help us come up with an——

Ms. SEBELIUS. I would be glad to work with you on that.

Mr. MURPHY. That would be extremely helpful because you know we have huge rates for vacancies of jobs in those centers and that would be very helpful. And I have no doubt that this committee and this House will pass it again. Will you help the nudge the Senators, help them understand the great value in this as well? We don't try and put pressure on them, but perhaps you could perhaps add some wisdom to them. Second thing—or the third thing, in the National Child Traumatic Stress Network—it is a group of academic and community based centers that give—that disseminate standards in clinical excellence and care of traumatized children. It is funded through the Substance Abuse and Mental Health Services Act. When I read your budget proposal, however, it seems like the Administration—although you were supportive of the program there were some cuts to the program. Actually it cut the funding from 40 million to 10 million, but at the same time the SAMSA budget is calling for major increases in spending in a number of other areas such as increased spending for military families initiatives for service grants, some things for homeless—certainly you know that with regard to homelessness there is a high correlation between childhood trauma and homelessness. And in my own experience of working with servicemen and women at Bethesda Naval Hospital, my own clinical experience as a psychologist also tells me that there is a higher risk for people for PTSD and homelessness and other trauma if they themselves experience a great deal of trauma in their lives when they were younger. And I think that you have like 2.37 billion in homeless grants through HUD and other things for veterans although I think the VA should be han-

dling some of this. Is this something you are able to relook at and see that perhaps we should be spending more in the early treatment and prevention, let the VA handle some of the other things for veterans, but to revisit that so make sure we are not cutting some of the treatment programs out of the childhood treatment of trauma?

Ms. SEBELIUS. Well, I would be glad to have that discussion with Pam Hyde, who is the Director of the Substance Abuse and Mental Health Services. I can tell you she is absolutely committed to prevention as being the most effective treatment possibility, so I will certainly circle back with her about your concern about that particular program.

Mr. MURPHY. Thank you. I know that the VA for example has 14 homeless programs and initiatives and although I do want to support all of those I also recognize that we would do well to prevent some of these problems for a lot of them, too. Finally in the area of Medicare and Medicaid those programs were designed in 1965 and I oftentimes liken it to none of us were driving a 1965 car and if we had one we would put a lot of patches and repairs to it over time. Whenever I talk to medical subspecialties in a wide range of areas—cardiology being one, I think 40 percent of our money is spent on cardiovascular disease. I very often—when we ask the question if you were to design Medicare today would it look anything like the Medicare of 1965? And I am assuming you would agree, no. Could you tell me what major initiatives you have in mind that really help us perhaps even redesign this from the ground up particularly for some of the major disease entities such as cardiovascular disease, lung disease, cancer, et cetera?

Ms. SEBELIUS. Well, Congressman, the Affordable Care Act actually includes a major direction that the Medicare incentives be redesigned and aligned with quality outcomes and healthcare strategies that we know are not only more patient-centered outcomes like medical home models and bundling care to prevent unnecessary hospital readmissions, but the Medicare incentives I would say are right now aligned to volume and not value. So we are in the process through the centers for innovation, through working with providers across this country to try and capture the best possible patient practices and implement those. Yes.

Mr. MURPHY. I hope you will do that. I know my time is up, but the academies and colleges of various specialties of medicine have standards and protocols and I hope you will look to them for some guidance on that.

Ms. SEBELIUS. We are working very closely with them. Thank you.

Mr. MURPHY. Thank you, Mr. Chairman. Thank you, Madame Secretary.

Mr. PITTS. The Chair thanks gentleman. The gentleman's time has expired. Chair recognizes the gentleman from Texas, Mr. Gonzalez, for 5 minutes for questions.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. Welcome, Madame Secretary. I do want to address a comment that was made by a fellow Texan that the uncertainty that is out there regarding the constitutionality of the mandate and wondering what the Texas Attorney General has to do and that he is wondering what he has

to do as well as our Governor Rick Perry. Those two gentlemen also represent me and I do have a suggestion as to what they could be doing in the meantime. They could be coming up with a solution to make healthcare insurance affordable for Texans so that employers have access to it at a reasonable price to offer it to their employees, and that Texas, its citizens have affordable insurance products available to them so that we don't lead the Nation in the uninsured. That is what they could be doing. That is just a suggestion. I am sure they have thought of it.

We have heard that the American people want us to balance the budget, reduce the national debt, and we all agree and I think the President's fiscal year 2012 budget places us in a good place to accomplish that. But I don't think the American people said and while you are doing this expose us to dangerous drugs, or continue a healthcare insurance industry that does not provide us adequate, affordable, accessible coverage. I don't think they said that. So I join you and I join the administration and I believe that I join members on the other side of the aisle in that objective. And we may have different plans on how to get there, but the truth is nothing was done until we passed the Affordable Care Act. The discussion is ongoing and it will be a continuing debate, but the need still exists, the problem still exists.

We can debate this thing and just continue to hemorrhage, so I will ask you this, Madame Secretary. We hear so much about market forces and just let the free markets take care of all of this. And I think in large measure we all agree with that to a point until the markets are dysfunctional, until the markets don't deliver what is necessary without the incentives, and the directions, sometimes and a push, and a shove, but mostly a collaborative effort which I think is what the President is seeking to do. When it comes to the FDA why not just let an industry police itself. Why don't we just let them do that?

Ms. SEBELIUS. Well, Mr. Congressman, we have seen I think the results of a lack of regulation in way too many areas that have just gone terribly awry. I think the FDA is certainly seeking to make sure that the 25 cents of every consumer dollar which comes in a product that is under the umbrella of that agency, whether it is drugs and devices or our food supply, is safe and secure. And frankly, I think in many cases the industry is very supportive of those efforts in the food debate for the new Food Safety bill that we just had, the industry ultimately takes the economic hit from an unsafe product being available to consumers. There is a huge ripple effect that ends up penalizing the food industry. So they are eager for a regulatory oversight and they are willing and able to actually help finance that regulatory oversight.

Mr. GONZALEZ. And I do believe it is a collaborative—it is a partnership. But I think Government has a responsibility to protect the welfare and safety and health of our constituents. That is what we were hired to do and provide them with opportunities. The last question is and I am very concerned about NIH because I am having all of my universities, they are all coming and these are Democrats and Republicans and they are all have basically this same request. What is going to happen to replace those particular funds that are so essential? Again why is NIH so necessary? Why don't

we just allow the public—the private sector to make those funds available to our universities?

Ms. SEBELIUS. Well, Congressman, as you know one of the areas that the United States leads the world is biomedical research. And it has been an enormously important partnership between the commercial industry and the research that goes on in universities across the country funded in large part by NIH which is why I think the President has recommended an increase to the NIH budget which is already looking at a losing the two years of enhanced funding from the Recovery Act and trying to make sure that we continue those breakthroughs that are happening all across this country.

Mr. GONZALEZ. Thank you very much. Thank you, Mr. Chairman for your indulgence.

Mr. PITTS. Gentleman's time is expired. The Chair recognizes the gentlelady from Tennessee, Mrs. Blackburn, for 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you, Madame Secretary for being with us. I found a—your opening statement a little bit curious. You mentioned that you think that it is the responsibility of the Administration to give every family and business the chance to thrive while making the investments that will grow our economy and create jobs. And I just have to tell you being out there and holding listening sessions in my district and with some of my colleagues the American people do not want to be dependent on the Federal Government for their cars, their loans, their home loans, their housing, their education, and their healthcare. What they would like to do is see the regulation reduced and to see the Federal Government get out of the way. So I would ask you, do you have any data that shows that businesses are actually getting relief on the cost of the insurance that they are paying every year? Do you have any data that is verified that this is lowering costs? Because we are hearing the opposite and are actually being shown bills and estimates for that.

Ms. SEBELIUS. Congresswoman, if you are talking about data as a result of the Affordable Care Act——

Mrs. BLACKBURN. Yes, of Obamacare. Yes, ma'am.

Ms. SEBELIUS [continuing]. As you know the law was signed just about a year ago. What we have seen with the enhanced rate regulation there are numbers of States that actually have used those new tools to lower the impact of rate increases and that is showing——

Mrs. BLACKBURN. Could you supply that because we are not seeing that in Tennessee——

Ms. SEBELIUS. I would be happy to supply that.

Mrs. BLACKBURN [continuing]. And I know Tennessee had to come to you for one of the 900 waivers. And I know they are appreciative for that. Let me ask you about the 1115 waivers. When you grant a waiver and it seem s like you all are doing more of that, is that waiver—does that take the elected officials in that State out of the decision-making equation? Is that waiver granted to the Governor's office between CMS and the Governor's office? Because that is the way TennCare was done. We as State legislators were taken out of the equation.

Ms. SEBELIUS. Actually Congresswoman, the traditional 1115 waiver was a dialogue between CMS and the Governor's office. The Affordable Care Act changes that provision so now there is a notice requirement. There are public hearing requirements. There is input opportunity, so the waiver process actually has been amended by the Affordable Care Act to include far more transparency.

Mrs. BLACKBURN. OK. I would like to call to your attention this is the reason it is so important to me. Today's Wall Street Journal: Obama's health waiver gambit. And it talks about Ms. Cutter and Ms. Deporal saying privately to our liberal interest groups that this is a way to increase centralization for instance with a State-based public option or even single payer. And I tell you why this is of concern to me. We had Governor Patrick in here this week and his Medicaid State Director is on the record having said that when you look at the way the market Medicaid works that he is beginning to favor a single payer. And I would just submit to you that this is not what the American people want. They do not want the Federal Government that can't tend to the items that are on their plate making the decisions for their healthcare and we hear it from them every single day and ma'am, it is of concern. If we have——

Ms. SEBELIUS. Congresswoman, that is not at all—first of all we don't design any waiver. The State comes to us with a——

Mrs. BLACKBURN. I have seen the applications from my State and I respect that and I understand that. We want to move on.

Ms. SEBELIUS. The rules aren't even developed for the program you are referencing.

Mrs. BLACKBURN. I do want to move on. Fraud, you mentioned fraud. We had a hearing on this this week. Are you able to quantify the amount of fraud that is there in Medicare and Medicare and then——

Ms. SEBELIUS. No, ma'am.

Mrs. BLACKBURN. OK. So the four billion that you feel like you saved you don't have a way to quantify what the problem is and how widespread?

Ms. SEBELIUS. We don't know how—if we knew how big it was we would hopefully shut it down.

Mrs. BLACKBURN. And what percentage of your energy this year is going to go to addressing that fraud?

Ms. SEBELIUS. What percent of my energy?

Mrs. BLACKBURN. Yes, your resources and energy. I mean, when we hear organized crime getting into Medicare and Medicaid fraud I think it should cause us all—so if you could just let us know your resources, what you plan to put into that.

Ms. SEBELIUS. There are significant new resources requested in the budget for fraud and abuse.

Mrs. BLACKBURN. Another question I would like to—your budget this year, your request is 891 billion. Your '08 budget which we would love to return to those numbers was 708 billion and you mentioned that you have cut in your testimony four programs but or you list four programs that you cut. Are those the only cuts that you all made or were there others?

Ms. SEBELIUS. No Congresswoman, there are about $5 billion worth of cuts. Our budget proposal is below the 2010 levels.

Mrs. BLACKBURN. Do you mind submitting that list to us?

Ms. SEBELIUS. I would be happy to.

Mrs. BLACKBURN. That would be great. You are below 2010, but not down to '08. I yield back.

Mr. PITTS. The chair thanks the——

Mr. PALLONE. Mr. Chairman——

Mr. PITTS [continuing]. Gentlelady.

Mr. PALLONE. Mr. Chairman, a point of personal privilege here or whatever——

Mr. PITTS. Yes, let me just say——

Mr. PALLONE. The Secretary should be allowed to answer the question.

Mr. PITTS. That is correct. The gentlelady's time is expired. Madame Secretary, do you wish to add additional response? You may continue to respond in writing as well if you feel like you have not adequately responded.

Ms. SEBELIUS. Thank you, Mr. Chairman.

Mr. PITTS. The Chair recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for questions.

Ms. BALDWIN. Thank you. Thank you, Madame Secretary for being here. Earlier I wanted to start by reacting to some of the other comments that were made. I think it was Dr. Burgess who noted that we switched sides and it was because of this law referring to Affordable Care Act or Healthcare Reform. And I disagree. I think the last election was about jobs, jobs, jobs.

But instead of focusing on jobs, the new majority has made it their first order of business to repeal the Affordable Care Act. That was one of the first votes we took this session which is already in my community providing lifesaving coverage to many who didn't have it before and improving their access and the affordability of their healthcare. And instead of focusing on jobs, the new majority has attempted also to deny funding to continue implementing the Affordable Care Act, the Healthcare Reform bill we passed last session.

Instead of focusing in on jobs, the new majority has offered House Resolution 1 that Moody's earlier this week said would lead to the loss of 700,000 jobs in the United States. And instead of focusing in on jobs, some of our new Governors are presenting budgets imbedded with policies that would gut Medicaid and would thwart at the State level the implementation of the Affordable Care Act. It is precisely what is happening in my home State of Wisconsin which used to have a reputation as being a leader in healthcare and a leader in preparation for the implementation of the Affordable Care Act.

Now I don't envy you your job right now. It is working to implement these vital, lifesaving, important reforms when so many are working so hard to see that legislation thwarted, roadblocks placed, et cetera. But I want to focus back on House Resolution 1, the continuing resolution that passed in the House a couple weeks ago.

I brought an amendment to the floor to restore funding to the community health centers. My amendment was fully paid for but unfortunately the Republicans barred me from offering that. But H.R. 1 slashes over a billion dollars to community health centers for the remaining seven months of this fiscal year. If this ultimately is passed and becomes law I guess I would like to hear from

you how you even go about implementing that. How does this impact the constituents that I represent that rely on the wonderful community health centers that provide services in my area? I have heard that this will impact coverage to probably 11 million Americans. It will result in job losses and closure of clinics. Do you drive—if you were forced to implement such draconian cuts how would you go about that? What would we see at the local level?

Ms. SEBELIUS. Well Congresswoman, I share your view that the community health center footprint is incredibly important and both with the Recovery Act and the budget investments and the Affordable Care Act that footprint will double over the period of the next five years serving closer to 40 million people. We are already seeing that increase. There are about 10 million additional Americans served thanks to the Recovery Act investments and they are in the most underserved areas. And with those community health centers are providers and often providing a host of community services.

So the effort to now deny care, fire healthcare providers who would lose their jobs and restrict access in the most underserved rural and urban communities to affordable available healthcare would just put additional burdens on already strapped city and State budgets. Those folks will come through the doors of emergency rooms, enlarge our numbers. They will be sicker on the job. They will be unable to take care of their kids. There will be students who won't do as well in school because their health needs won't be attended to. And I think that has a serious impact not only in the health of this Nation but on certainly the prosperity of the Nation.

Ms. BALDWIN. Thank you.

Mr. PITTS. The gentlelady's time is expired. Chair recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you. Secretary Sebelius, in testimony before this committee on January the 26 I asked Mr. Cass Sunstein from the White House Office of Regulatory Affairs if he knew who had the authority within your administration to slip a Medicare end of life service rate into a final rule without first allowing for public comment. And he testified under oath that and I quote "the Secretary of HHS has considerable authority over her rules." Madame Secretary, in—yes or no, did you make the decision to publish this end of life payment rate without allowing for public comment?

Ms. SEBELIUS. Yes, sir.

Mr. GINGREY. Well, I appreciate your forthrightness on that. I really do, but you know it flies in the face of the comment, the response that you just gave to my colleague from Tennessee regarding the 1115 Waiver Program and you described how it formally worked between the department and directly with the Governor's office in calling for more oversight and public hearing and transparency. So would you agree that in the future that rather than making that decision unilaterally even though you have the power to do it, that maybe a little bit of time for public comment would have been appropriate in regard to that?

Ms. SEBELIUS. Congressman, the rule as you know was—followed the outline that was directed in the Affordable Care Act in terms of the provisions for a wellness visit. In addition we looked at the

original welcome—welcome to Medicare visit and the one element that wasn't consistent was——

Mr. GINGREY. Yes, I wish I had enough time to listen to your full answer but——

Ms. SEBELIUS [continuing]. End of life—but—well, we did——

Mr. GINGREY [continuing]. If you could respond yes or no to that? More transparency? More opportunity for public comment?

Ms. SEBELIUS [continuing]. We got in fact—yes, sir. And that is why it is not part of the final rule. We decided that it was better to air it.

Mr. GINGREY. And I would hope that that is a yes answer. Let me move on. In the President's fiscal year 2012 budget, your department requested $93 million for information in education in order to sign American workers up for the Class Act. This is that same program that you just recently told Senate Finance Committee I guess a few weeks ago that the program was unsustainable. Now those are your words. Do you believe it is appropriate for the Administration to solicit money from American workers for a health program that is "totally unsustainable"?

Ms. SEBELIUS. Sir, my comment was that it was unsustainable as the legislation was crafted, but I was given considerable flexibility and we are in the process of making I think the changes that will meet the criteria outlined in the law, which is, that it be sustainable without taxpayer support.

Mr. GINGREY. Well, thank you. Given the current budget crisis that we have in this country and I think everybody on the dais and certainly you would agree with this we have a tremendous budget crisis. And understanding that you are asking for money to sign people up for a program that you say is unsustainable, will you pledge here today to work with this committee to ensure that the Class Program, the Class Act is truly sustainable before the Administration proceeds with program operations?

Ms. SEBELIUS. Yes, sir, I would be happy to do that.

Mr. GINGREY. Thank you, Madame Secretary. And the last thing that I wanted to address with you and this is kind of a follow on to Chairman Dingell's line of questioning earlier regarding H.R. 1. And he asked you a number of yes or no questions, and I think you responded to pretty much everyone of them yes that H.R. 1 and the $61 billion worth of cuts would hurt this program and that program and the other program. Do you believe that we need to restore fiscal sanity to our budget? Yes or no?

Ms. SEBELIUS. Yes, sir.

Mr. GINGREY. Do you believe then that the $61 billion in discretionary cuts in the CR for fiscal year 2011 contained in H.R. 1 will help the Federal Government reduce its current budgetary deficit? Yes or no?

Ms. SEBELIUS. Sir, I believe that the President has put a very responsible budget forward and it is one that——

Mr. GINGREY. I am not talking about 2012 now, Madame Secretary. I am talking about H.R. 1, the CR and the $61 billion worth of cuts that Chairman—former Chairman Dingell was attacking.

Ms. SEBELIUS. I support the President's notion that we have to make smart and strategic cuts because we have got budget——

Mr. GINGREY. So the answer is yes. I thank you, Madame Secretary. And Mr. Chairman, I will yield back my 13 seconds.

Ms. SEBELIUS. I don't think the answer was yes, but——

Mr. PITTS. Chair thanks the gentleman. Gentleman's time is expired and the Chair recognizes the gentleman from New York, Mr. Weiner, for 5 minutes for questions.

Mr. WEINER. Thank you, Madame Secretary. Welcome. As to this notion that we didn't invite you to come testify last year after the passage of the bill, having heard these questions all I have to say to you is you are welcome. I just wanted—probably no member of the Government, maybe even in history, has had to spend so much of her time swatting away lies. So let me kind of run through some things. Maybe we can cover in four minutes and 33 seconds to try to get some truth on some of the big questions of the day.

First of all, this notion that if you give people a subsidy and incentive to purchase health insurance somehow that they are not going to want it, that this individual mandate is somehow this huge burden. You might not be aware of this, but I will tell you the number of people in Romney Care in Massachusetts which also had a mandate that chose not to sign up after they got the subsidy; chose instead to pay for the penalty or the tax—whatever we are going to call it, was .65 percent. Meaning that when you offer the people to get insurance for their families to get better healthcare and a better life they take it.

So the idea that this mandate if it disappears will somehow have a dramatic impact, maybe one percent of people would be impacted. But just so we understand and you can clear it up for us—the reason there is a requirement that people get insurance when offered a subsidy and incentives to get it, it is because if they don't get it and they are uninsured when they need hospital care or healthcare costs, they pass it along to the rest of society. Is that right?

Ms. SEBELIUS. That is correct. That is correct.

Mr. WEINER. The second thing is we have heard a lot of the—in the repeal efforts this being called a job killing bill. If we repeal the Healthcare bill would the subsidies going to small businesses, the tax credits to provide healthcare for their workers making those workers less expensive, would those subsidies disappear if we repeal the bill?

Ms. SEBELIUS. Yes, sir.

Mr. WEINER. Thank you. Next is this notion about Medicaid providing this enormous unfunded liability in the out years. Is it not true that under the bill any additional people covered under Medicaid which are poor people but they are not going to be as poor under the new bill since we are going to raise the limit a bit—not to a lot, it is still—you have to have a $30,000 family income for a family of four. It is not a lot of money. That the—it provides no additional cost at all to the States until at least the year 2017. Is that correct?

Ms. SEBELIUS. That is correct.

Mr. WEINER. And in the year 2018 when there is a marginal difference, if the number of poor people in the States goes down, meaning the economy has improved, meaning fewer people are poor enough to be eligible for Medicaid, more people are working, those

costs could go down as well if there are fewer people on Medicaid. Could there not?

Ms. SEBELIUS. That is correct.

Mr. WEINER. And I assume that all of us believe and we hope that the economy is going to keep getting better. We have Republican Governors here saying my costs are going to go through the roof. Well, they only go through the roof if you are a crummy Governor and your poverty in your State continues to go up. Is that correct? Well, you—never mind, never mind, never mind.

Ms. SEBELIUS. Thank you.

Mr. WEINER. You can leave off the crummy Governor part. That is me editorializing. Finally, another thing my Republican friends have said again and again is this is a trampling of states' rights, that the most powerful Secretary is taking more and more control. I am going to give you a couple of things here. First of all, is it not true that the exchanges are going to be run by the States?

Ms. SEBELIUS. If they choose to do so, absolutely.

Mr. WEINER. If they choose to do so. Is it not true that the tort laws which are now States by States—there was a decision made in this law by the people who wrote the law not to trample on states' rights with tort laws but now the 50 States still have their Tort Laws in effect. Is that correct?

Ms. SEBELIUS. That is correct.

Mr. WEINER. Is it also not true that State insurance commissioners and commissions and the State governance of insurance was left intact?

Ms. SEBELIUS. At the State level with additional resources for those States.

Mr. WEINER. Correct. We actually empowered them. They now have the ability——

Ms. SEBELIUS. Correct.

Mr. WEINER [continuing]. To do things to hold down rates and so forth. So much for this notion of we are centralizing power in your office or centralizing the Federal Government. We went in an opposite direction. We did not go the direction I would have like to expanding Medicare which is a much better idea by the way Madame Secretary—expanding Medicare little by little. We went a different way.

And one final point on this notion of expanding the office—your power of your office. These 1115 waivers that you have been given are an effort each one is you saying we are going to be flexible to allow to respond to your expression of what is going on in the States, in the marketplace, at the business so long as we get to the outcome we all aspire to which is more people getting affordable coverage, reducing the cost to people along the way. Isn't it the waivers makes the point that this is not this intractable, inflexible, centralized monolith, that it is a conversation that is going on between States and businesses and your office to try to make sure we get the outcomes we all want?

Ms. SEBELIUS. I think the bill recognizes the framework that States know their markets best. They are the laboratories of innovation, they work to provide a State——

Mr. WEINER. But on those waivers are an expression of that as well, are they not?

Ms. SEBELIUS. Absolutely.

Mr. WEINER. OK. In 5 minutes we did one, two, three, four, five, six, seven, eight, nine lies told by the Republicans. Imagine if we had more time but we don't. Thank you, Madame.

Mr. PITTS. The gentleman's time is expired. The Chair recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes.

Mr. LATTA. Well, thank you, Mr. Chairman. Secretary, thank you very much for being with us today. And I am going to—I would like to change track just a little bit and in reading your testimony on page eight under the Advance the Health Safety and Wellbeing of the American People it says child support and fatherhood initiative. And the two sentences I am interested in—the budget includes 305 million in fiscal year 2012 and 2.4 billion over 10 years for the child support and fatherhood initiative.

This initiative is designed to promote strong family relationships by encouraging fathers to take responsibility for their children changing policies so that more of the father's support reaches their children continuing a commitment to vigorous enforcement. I guess my first question, Madame Secretary, is where it states here that we are going to encourage fathers to take responsibility for their children. What encouragement are we going to be offering them?

Ms. SEBELIUS. I think it, Congressman, it refers to working with States on a more effective and vigorous enforcement of child support orders and seeking child support orders from the outset, and making sure that there is a financial connection between fathers and their children that they have borne.

Mr. LATTA. OK. Let me follow up with that. And the reason I ask—this really caught my attention because several lifetimes ago I was in the Ohio Senate. I chaired the Senate Judiciary Committee and we had a large bill that I had—that I sponsored in dealing on especially juveniles and juvenile crime, et cetera. And one of the judges that appeared before us during about I think it was like 18 or 19 hearings on that piece of legislation. That as we were going through it and we were talking about parents it really came down to and I think this one judge really caught the essence of the entire day. He said it was really—and what we are looking at is an abdication of parental responsibility. And I guess the next question would be then is that do we have any current programs, models that we can base the belief or successes that this is going to work with?

Ms. SEBELIUS. I am sorry, sir. Do we have——

Mr. LATTA. Do we have any current programs or any other models out there that is going to show—you know if we are going to spend 305 to 2.4 billion over 10 years do we have anything out there that is going to show that this is going to work?

Ms. SEBELIUS. Well, we have—I think this is part of the TANF umbrella and I do think we have data that indicates there are strategies that are more effective than others and what we are trying to do is improve this effort along the way to make sure that child support is not only effectively administered but that more of these dollars will actually go to the children and not be siphoned off along the way. So it is a double improvement.

Mr. LATTA. OK. And I guess the—you know it really comes down to you know can Government really change some of these folks out

there, the way that they are parent—I would guess you would say non-parenting right now?

Ms. SEBELIUS. Well——

Mr. LATTA. And if I could just—and I am going to pose this too even going back on a farther lifetime we used to have what they called Bureau Support. And I remember when I was working in the prosecutor's office many moon ago I asked one gentleman if he wanted to go to jail for not paying his support and he said I don't care. And those are the kind of——

Ms. SEBELIUS. Well, unfortunately, I wish there was a law that you could pass that would do just what you are suggesting, but at a minimum I think that what we can do is be effective in terms of trying to make sure that children are not penalized financially by a father who would walk away. But I think this also includes fatherhood engagement increases, and increased access in visitation. Often those two things are tied together. If a father is really prohibited from connecting with his children, he is less likely to be a financial provider. And so I think it looks at the whole, the overall package of family.

Mr. LATTA. And if I could just—my last minute here going back to a question that has come up I know from Mr. Pallone, it is a question of—it is in the page 3 the budget limited subsidies to Children's Hospitals Graduate Medical Education. And it says if—in focusing instead on targeting those investments to increase the primary care work force. I know a lot of the time when people are coming in from Children's Hospitals from Ohio that they say that they are the step children, that they are not getting the dollars. They are not getting the dollars from NIH. What are we targeting then in your testimony it says instead targeted investments to increase primary care workforce?

Ms. SEBELIUS. Well, the—again, I don't think this is an easy cut to put on the table and I can guarantee you that in a budget that we had full resources this would not be a preferred cut. The GME dollars are being redirected to, I think, programs that have as an exclusive focus the sort of primary care provider network recognizing that we are going to need additional primary care docs looking forward.

Mr. LATTA. Thank you, Mr. Chairman. My time has expired and I yield back.

Mr. PITTS. Gentleman's time has expired. Chair recognizes the gentlelady from Illinois, Ms. Schakowsky for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. Madame Secretary, I want to thank you so much for being here today. We have asked you to lead a historic effort and I can't think of anyone better able to do that given your experience as an insurance industry regulator and as a Governor. So clearly you have the mindset of Governors as you go about your business.

We have asked you to reign in an out of control private insurance industry that on a daily basis denies coverage and benefits to healthcare consumers. I am interested that my colleagues on the other side of the aisle seem more interested in arranging your office structure than rooting out those abuses. And I am interested that they have attacked the size of the new Center for Consumer

Information and Insurance Oversight. By my calculation the 272 positions that you have requested to staff CCHO is the equivalent of about 16 House offices. I know our staffs work very hard just as your staff does, but I don't think that is an enormous number of people when we have tasked them with setting up the new standards and structures created under the Affordable Care Act.

Let me also say you know that we heard from the other side of the aisle this notion that all that Americans really want is for government to get out of the way when it comes to their healthcare. That is really not my impression in the least. We certainly don't need more evidence than the popularity of Medicare, the importance of Medicaid leaving the Affordable Care Act aside. But is it your sense that what the American people want is to reject help from the Government to cover their healthcare——

Ms. SEBELIUS. Well, as you said, Congresswoman, I think Medicare is——

Ms. SCHAKOWSKY [continuing]. To assure their coverage?

Ms. SEBELIUS [continuing]. Enormously popular and I think the—probably the second most popular insurance program may be the Children's Health Insurance Program both of which are Government-based programs delivering vital services to millions and millions of Americans.

Ms. SCHAKOWSKY. And I think it is just important to say over and over again that, far from being a Government takeover of healthcare, that the Affordable Care Act, though some of us felt perhaps it shouldn't be this way, relies entirely on the private insurance companies with some help from the Government, that this is a private-sector-based plan that we do—that we are doing. So let me ask a few questions on behalf of my constituents.

If you were denied funding to implement the Affordable Care Act, the Affordable Care, will health insurance purchasers know that at least 80 percent of their premium dollars will be spent on medical care? Purchasers—will we have any guarantee that that will happen?

Ms. SEBELIUS. It will be very difficult to implement the medical loss ratio as you have described.

Ms. SCHAKOWSKY. In States like Illinois without any rate approval requirements, how would rates that are out of line even be enforced?

Ms. SEBELIUS. Well, again I think it would be—one of the requirements is that we help to identify excessive rates and at least post them so consumers have some way of judging. But that would not be available to consumers.

Ms. SCHAKOWSKY. But with the Affordable Care Act, yes, I think we would get some help in Illinois.

Ms. SEBELIUS. Right.

Ms. SCHAKOWSKY. But without it we are simply——

Ms. SEBELIUS. That is correct.

Ms. SCHAKOWSKY [continuing]. Totally at the mercy of the insurance companies. What does it mean for seniors and people with disabilities who are counting on the phase "out of the doughnut hole" if the Affordable Care Act were ultimately repealed?

Ms. SEBELIUS. Well, clearly those additional benefits to seniors—which include, as you know, annual wellness visit, an elimination

of co-pays for preventive screenings and health and, as you say, a gradual elimination of the doughnut hole starting this year with a 50 percent discount—that would cease to be a Medicare benefit.

Ms. SCHAKOWSKY. All those things just disappear. Let me quickly say, I am wondering, because process has been attacked, can you tell us briefly the process through which HHS adopted the rules that deal with the 80 percent loss ratio?

Ms. SEBELIUS. Well, Congresswoman, we were directed and followed this very carefully working with the Nation's insurance commissioners to ask for their input and advice on the outline of a medical loss ratio—what portion, what element should be included in the medical portion of the 80 percent and what should be outside that. They made a unanimous recommendation to our office.

This fall we adopted 100 percent of what they recommended to us and that is the rule. So this is not an HHS rule in so far as we did not design it. The Nation's 50 insurance commissioners made the recommendation which we adopted.

Mr. PITTS. The gentlelady's time is expired and Chair recognizes gentleman from New Jersey, Mr. Lance, for 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman, and good morning to you, Madame Secretary.

Ms. SEBELIUS. Good morning.

Mr. LANCE. I am new to the committee and I look forward to working with you on issues of mutual concern. I have the honor of representing a district that is arguably the medicine chest of the Nation and I would like to think of the entire world. And regarding the President's proposed budget there is a suggestion that the data exclusivity be reduced from 12 years to 7 years. I personally oppose that and I do not think it is in the best interest of the Nation's health. There has been extensive economic modeling on this at Duke University and the modeling indicates that there is a range of between 12 and 16 years is the time needed to allow an innovator in bio-pharma to recoup the amount spent in order to bring to market needed medicines in this regard. And Madame Secretary, I would like your comments regarding the suggested reduction in the fiscal year 2012 budget on data exclusivity from 12 to 7 years.

Ms. SEBELIUS. Congressman, I think there is a great importance in making sure that we continue to accelerate our leading position in breakthrough science. And certainly your State is renowned for being a great leader in that.

Mr. LANCE. Thank you.

Ms. SEBELIUS. I think the balance, as you recognize, is not only making sure that companies can recoup their investment and are profitable—because if they are not profitable, they are not going to continue research—but that, as quickly as possible, once that determination has been made, that breakthrough medication is also widely available and affordable to the population. And that is attention that I think continues to exist.

The president believes that based on information—and I know that there are competing experts on how long and——

Mr. LANCE. Yes.

Ms. SEBELIUS [continuing]. How much evergreening should go beyond the patent protection, that seven years would indeed accom-

plish the goals of both returning the profit and continuing the research but also making the medication widely available.

Mr. LANCE. Thank you for your response. The last time this committee examined this issue in an overwhelmingly bipartisan fashion the committee chose to retain the 12 years and I look forward to continuing discussions with your department on this matter. Secondly, Madame Speaker, regarding PADUFA there is the challenge now with its reauthorization and at the most recent reauthorization there was included the REMS, the Risk Management and Mitigation Strategies and at least in some instances it is my judgment that this has been a challenge. For example, Johnson and Johnson had a product on the market for over 20 years and was required to submit a REMS that took over 22 months to resolve. Your comments, Madame Secretary regarding this as we go about reauthorizing PADUFA over the next year?

Ms. SEBELIUS. Well again, I think it is an area where we are mindful of time delays on behalf of not only companies but certainly consumers—at the same time I think mindful of the very important safety efforts and I look forward to working with you on that striking the right balance.

Mr. LANCE. Thank you and I appreciate your comments in both of these important areas that I think go to the heart that we have to work together in these areas as we make sure that the Nation's health is protected and that we remain the medicine chest of the entire world. I yield back the balance of my time.

Mr. PITTS. Chair thanks gentleman and recognizes gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Hey, Madame Secretary, I am not so hurried now. First I want to thank Mr. Pallone because apparently he is committed to working on equity for FMAP payments, or at least Federal support of care for the poor, and I will submit two articles for the record with unanimous consent: one from the GAO, one from AEI talking about the current inequity in that situation.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

United States General Accounting Office

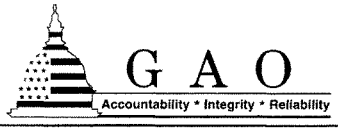
GAO

Report to the Honorable Dianne Feinstein, U.S. Senate

July 2003

MEDICAID FORMULA

Differences in Funding Ability among States Often Are Widened



GAO-03-620

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Highlights

Highlights of GAO-03-620, a report to the Honorable Dianne Feinstein, United States Senate

July 2003

MEDICAID FORMULA

Differences in Funding Ability among States Often Are Widened

Why GAO Did This Study

A primary goal in establishing Medicaid's statutory formula, whereby states with lower per capita incomes (PCI) receive higher rates of federal reimbursement for program costs, was to narrow differences among states in their ability to fund Medicaid services. States' ability to fund services depends on their financial resources in relation to their number of and costs to serve people in poverty. GAO and others have testified before Congress that the current formula does not address wide differences among states in their ability to fund their Medicaid programs and that the formula's reliance on PCI is the primary cause. GAO was asked to determine the extent to which the formula narrows these differences and to identify factors that impede further narrowing of differences.

To evaluate the extent to which the formula narrows differences in states' funding ability, GAO used an alternative to PCI that more directly measures states' resources, number of people in poverty, and cost of providing services to this population. Using this measure, GAO determined the effect of the current formula by comparing states' funding ability before and after receiving their federal matching aid. If differences in funding ability were eliminated, the formula would have reduced differences by 100 percent.

www.gao.gov/cgi-bin/getrpt?GAO-03-620.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

The Medicaid formula narrows the average difference in states' funding ability by 20 percent but often widens the gap between individual states and the national average. Although the receipt of federal matching aid moves 30 states closer to the national average, making the average difference in funding ability smaller, it also moves 21 states farther away from the average, widening the average difference. These 21 states include 3 that are among the states with the largest populations in poverty—California, Florida, and New York. After federal matching aid is added, states' funding ability ranges from 26 percent below the national average for two states to 179 percent above for another. Because of the formula's current structure, in many instances, two states devoting similar proportions of their own resources to Medicaid can spend very different amounts per person in poverty. For example, in fiscal year 2000, California and Wisconsin each devoted about $8 for every $1,000 of their own state resources toward Medicaid. However, under the current formula, Wisconsin receives a relatively high federal matching rate despite its relatively high ability to fund program services, whereas California receives a low federal matching rate despite its relatively low ability to fund program services. With the addition of federal matching aid, Wisconsin is enabled to spend more than twice what California is able to spend per person in poverty ($7,532 versus $3,731).

Two factors constrain the formula from further decreasing differences in states' funding ability. First, PCI is not a comprehensive indicator of a state's total available resources and is a poor measure of the size of and cost to serve a state's people in poverty. Second, the statutory provision that guarantees no state will receive less than a 50 percent matching rate benefits many states that already have above-average resources to fund health care for their populations in poverty. For example, 2 of the 11 states that benefit the most from the 50 percent "floor" receive matching rates that are 35 and 20 percentage points higher, respectively, than the rates they would receive based solely on their PCI.

GAO received comments on a draft of this report from two external reviewers who have Medicaid formula expertise. They generally agreed with the analysis and provided technical comments, which were incorporated as appropriate.

Contents

Figures

Abbreviations

BEA	Bureau of Economic Analysis
BLS	Bureau of Labor Statistics
CMS	Centers for Medicare & Medicaid Services
CPS	Current Population Survey
DSH	disproportionate share hospital
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
GSP	Gross State Product
HUD	Department of Housing and Urban Development
PCI	per capita income
PPS	Prospective Payment System
SIC	Standard Industrial Classification
SPI	state personal income
SSA	Social Security Administration
TTR	Total Taxable Resources

GAO
Accountability • Integrity • Reliability
United States General Accounting Office
Washington, DC 20548

July 10, 2003

The Honorable Dianne Feinstein
United States Senate

Dear Senator Feinstein:

Created in 1965, Medicaid is the largest federal program assisting states in financing medical and health-related services for certain categories of the country's low-income population. In fiscal year 2000,[1] Medicaid served about 43 million beneficiaries and had expenditures totaling about $196 billion, $111 billion of which was financed by the federal government and the rest financed by the states.[2] The federal share of total Medicaid program costs is determined using a statutory formula that calculates the portion of each state's Medicaid expenditures that the federal government will pay, known as the Federal Medical Assistance Percentage (FMAP), referred to in this report as the federal matching rate.[3] The formula calculates the federal matching rate for each state on the basis of its per capita income (PCI) in relation to national PCI. States with a low PCI receive a higher federal matching rate, and states with a high PCI receive a lower rate. The Medicaid statute also provides for a 50 percent minimum federal matching rate ("50 percent floor") that reflects a federal commitment to fund at least half the cost of each state's program.[4]

One of the goals of the formula has been to narrow differences among states in their ability to fund Medicaid services, which is determined by a state's financial resources in relation to its low-income population. By providing higher matching rates to states with low PCI, it was expected that these states would be in a better position to provide health care

[1]Fiscal year 2000 is the latest year for which Medicaid data on spending and the number of beneficiaries served were available.

[2]Medicaid programs operate in the 50 states, the District of Columbia, and five U.S. territories. In this report, "states" refers to the 50 states and the District of Columbia.

[3]Three other programs—the State Children's Health Insurance Program, Adoption Assistance, and Foster Care—also use the Medicaid matching formula to establish federal matching rates. These three programs accounted for an additional $7.49 billion in federal funding in fiscal year 2000.

[4]42 U.S.C. § 1396d(b)(1) (2000).

services to low-income populations. (App. I contains a legislative history of the formula.)

In 1995, we and other witnesses testified before the Senate Committee on Finance that the current Medicaid formula did not adequately address wide differences among states in their ability to fund program services and that the formula's reliance on PCI is the primary cause. Witnesses generally testified that PCI is an unreliable indicator of states' ability to fund Medicaid programs.[5]

Because the formula has not been changed since the program's inception and concerns persist regarding its performance with respect to narrowing differences in states' ability to fund program services, you asked us to address the following questions: (1) To what extent does the Medicaid formula reduce differences in states' ability to fund program services? (2) What factors prevent the formula from further narrowing differences in states' funding ability?

To evaluate the extent to which the formula narrows differences in states' ability to fund program services, we defined a state's ability to fund its Medicaid programs as the financial resources potentially subject to state taxation relative to its number of low-income residents, adjusted for the cost of providing health care to them.[6] For state resources, we used Total Taxable Resources (TTR), a measure of all income potentially subject to taxation that is either produced within a state or received by state residents from out-of-state sources. TTR is reported annually by the

[5]U.S. General Accounting Office, *Medicaid: Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226 (Washington, D.C.: July 27, 1995); Jerry Cromwell, testimony before the Senate Committee on Finance, *Improvements in the Federal Medicaid Matching Formula*; and Robert P. Strauss, testimony before the Senate Committee on Finance, *Revising the Medicaid Reimbursement Formula in an Era of Fiscal Austerity*, 104th Congress, 1st sess., July 27, 1995.

[6]We measured states' funding ability on the basis of *potentially* taxable resources and *potentially* eligible participants in Medicaid so that our measure of funding ability, before federal matching aid is taken into account, does not reflect the influence of states' individual policy choices. The matching formula also affects states' decisions about the amount and type of Medicaid services they provide and therefore affects the availability of health care to low-income individuals as well. However, we did not evaluate the formula's performance in terms of equalizing access to care because of the high degree of uncertainty in predicting how individual states' spending decisions are affected by changes in matching rates.

Department of the Treasury.[7] To determine the number of low-income people in each state ("people in poverty"), we obtained the Bureau of the Census's counts of people with incomes at or below the federal poverty level (FPL).[8] We adjusted the counts of people in poverty to reflect (1) the higher cost of serving the elderly, who utilize health care services at higher rates than other age groups, and (2) geographic differences in the cost of medical personnel, facilities, and supplies used to deliver health care services. To adjust for age differences in people in poverty, we used data on Medicaid spending by age group from the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS).[9] We used 5-year averages of people in poverty for each age group for 1995 through 1999 to increase the reliability of the state-level population counts because they are subject to statistical error, especially in smaller states. To measure geographic differences in the cost of medical personnel, facilities, and supplies, we used data from the Department of Labor's Bureau of Labor Statistics (BLS) and from the Department of Housing and Urban Development (HUD).

We compared states' funding ability from their own resources with their funding ability after their resources have been augmented to include the value of the federal Medicaid matching aid they receive. Throughout this report, we refer to augmenting a state's taxable resources this way as state funding ability with the "value" of federal matching aid included. If differences in funding ability were completely eliminated by adding the value of federal matching aid, the formula would have reduced differences in states' funding ability by 100 percent. We did our work between June 2001 and June 2003 in accordance with generally accepted government auditing standards. (App. II provides a more detailed discussion of our methodology.)

[7]We used 3-year averages of TTR (for 1996 through 1998) to parallel the use of 3-year averages of PCI in the current formula (see app. I for a more detailed description of the current formula).

[8]The federal government bases Medicaid eligibility on a variety of categorical and income-related factors, and states may expand their programs beyond the minimum requirements. As a result of the flexibility given states in administering their Medicaid programs, except for children and pregnant women, there is no federal minimum income level below which individuals must be covered under Medicaid that can be used as a basis for measuring potentially eligible low-income individuals.

[9]We used CMS data on average per capita Medicaid spending for elderly (aged 65 and over) and other beneficiaries to determine how much to weight the numbers of people in poverty who are elderly to reflect the higher cost to provide them services.

Results in Brief

The current Medicaid formula narrows the average differences in states' funding ability by 20 percent, but it often widens the gap between individual states and the national average. Although the formula moves 30 states closer to the national average funding ability after they receive their federal matching aid, making the average differences in funding ability smaller, it moves 21 states farther away, including 3 states that have 30 percent of the nation's population in poverty—California, Florida, and New York. After the value of federal matching aid is added, states' funding ability ranges from 26 percent below the national average for two states to 179 percent above the national average for another. Because of the formula's current structure, in many instances two states devoting roughly the same proportion of their resources to Medicaid are able to spend very different amounts per person in poverty. For example, in fiscal year 2000, Wisconsin and California devoted the same proportion of their states' own resources to fund their Medicaid programs (about $8 per $1,000 of TTR). Yet, after receiving federal matching aid, Wisconsin's funding ability was almost 50 percent above the national average and California's was 26 percent below the national average. Because the current Medicaid matching formula does not reflect the fact that Wisconsin has fewer people in poverty and lower costs to provide health care services to its population in poverty than California, Wisconsin's federal matching aid enables it to spend more than twice what California could spend per person in poverty—$7,532 compared with $3,731.

Two factors prevent the Medicaid formula from further narrowing differences in states' funding abilities. First, the formula uses PCI to calculate the federal matching rate, but it is a poor proxy measure for the components of funding ability—states' resources and the size of and costs to serve their populations potentially eligible for Medicaid services. Second, the 50 percent minimum federal matching rate disproportionately benefits states that already have above-average resources to fund health care for their populations in poverty. The 50 percent "floor" thus prevents further narrowing of funding abilities by giving some states federal matching rates significantly higher than they would otherwise receive without the floor.

We received comments on a draft of this report from two external reviewers with Medicaid formula expertise. They generally agreed with our analysis and provided technical comments, which we incorporated as appropriate.

Background

Medicaid eligibility is determined by several factors, including an individual's or a family's income in relation to the FPL, age, and eligibility for certain other federal program benefits. For example, federal law requires state programs to cover pregnant women and children under age 6 if their family income is at or below 133 percent of the FPL, children under age 19 in families with incomes at or below the FPL, and individuals who receive Supplemental Security Income because they have disabling conditions.[10] For most covered populations, state Medicaid programs are required to offer certain benefits, such as physician services, inpatient and outpatient hospital services, and nursing facility and home health services. State Medicaid programs must provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for most children,[11] intended as comprehensive, periodic evaluations of children's health and developmental history, that include vision, hearing, and dental screening.

States' Medicaid programs can differ dramatically because states may expand their programs beyond the minimum requirements to cover, for example, individuals whose incomes exceed federally mandated eligibility thresholds and optional services, such as prosthetic devices and prescription drugs. For example, a state may extend Medicaid eligibility to certain population groups, such as pregnant women who have family incomes above 133 percent of the FPL, or make optional services such as prescription drugs available to its entire covered population.

Since the Medicaid program began, total program costs have been apportioned between states and the federal government using a formula that provides more generous federal matching aid to states with lower PCI.[12] The use of PCI in federal grant formulas dates to 1946, when it was

[10]In the majority of states, individuals who receive SSI are automatically eligible for Medicaid. Eleven states have more restrictive Medicaid eligibility standards through section 1902(f) of the Social Security Act. These 11 states are often referred to as "209(b) states" because the origin of this authority was section 209(b) of the Social Security Amendments of 1972. Pub. L. No. 92-603, 86 Stat. 1329, 1381 (codified as amended at 42 U.S.C. § 1396a(f) (2000)).

[11]EPSDT services are optional for the medically needy population, a category of individuals who generally have too much income to qualify for Medicaid but have "spent down" their income by incurring medical care expenses. See 42 U.S.C. § 1396(a)(10)(C) (2000).

[12]Matching rates are calculated using the following formula:

$$\text{Federal Matching Rate} = 1.00 - 0.45\left(\frac{\text{State PCI}}{\text{U.S. PCI}}\right)^2$$

chosen as a proxy for a state's ability to fund public services. Consistent with the purpose described in the formula's legislative history, PCI is used as a proxy for both state resources and the low-income population. As a state's PCI increases, relative to the national average, the formula provides for a decreasing federal matching rate, meaning the federal government shares a smaller portion of a state's costs. By statute, the federal matching rate may range from 50 percent to 83 percent.[13] The formula's multiplier, currently 0.45, represents the state's share of its total Medicaid costs for a state with PCI equal to the national average, and the federal government thus pays a 55 percent share of total costs.

Medicaid Formula Narrows Differences in Some States' Funding Ability and Widens Differences in Others

The Medicaid formula reduces by 20 percent the differences among states in their ability to fund program services, compared with the national average funding ability. While the formula narrows differences for 30 states, making the average difference in funding ability smaller, it moves 21 states farther away from the national average, making the average difference wider. These 21 states include 3 that are among those with the largest populations in poverty—California, Florida, and New York. Because of the formula's current structure, in many instances, two states devoting the same proportion of their own resources toward funding Medicaid services are unable, after receiving federal matching aid, to spend the same amounts per person in poverty, adjusted for cost differences related to age and geographic location.

Formula Reduces Overall Differences in States' Funding Ability by 20 Percent

Because state resources, numbers of people in poverty, and the cost of serving this population vary widely across the states, there also are wide differences in states' ability to fund health care services. Considering these indicators of state funding ability, Alaska has the highest funding ability—exceeding the national average by 119 percent—and Mississippi has the lowest funding ability—46 percent below the national average, as measured using states' TTR and the number of people in poverty, adjusting the poverty count for age and geographic cost differences (see fig. 1). Nationwide, the average difference between a state's funding ability and

[13]In fiscal year 2003, Mississippi had the highest federal matching rate of any state—76.6 percent.

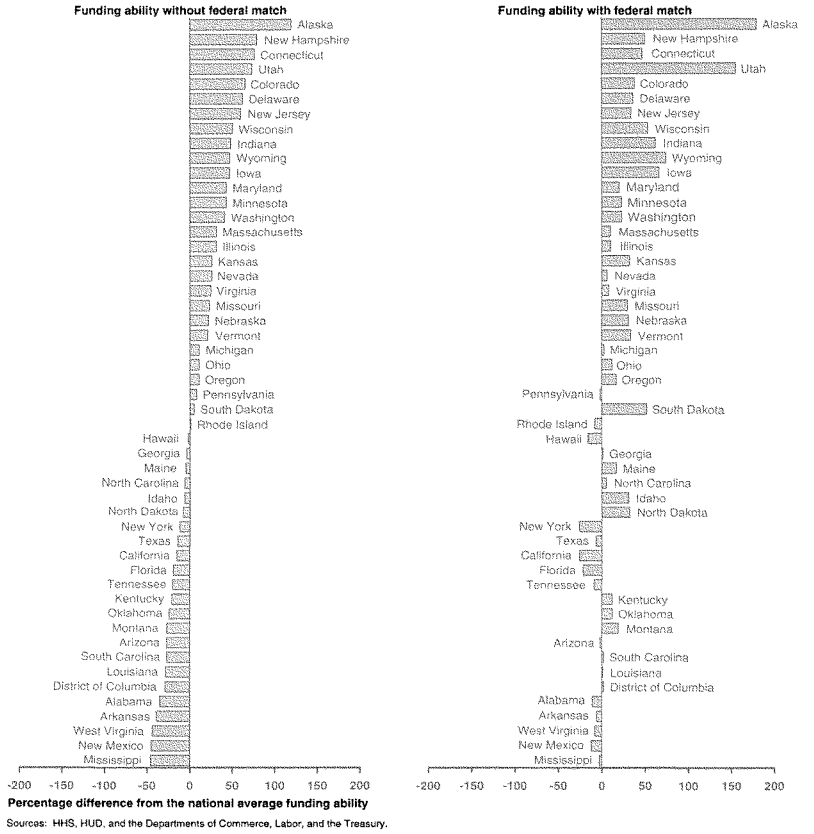
that of the average state is 22.7 percent.[14] Nineteen states have funding ability 25 percent or more above the national average, and 10 states have funding ability 25 percent or more below the national average.

After the value of federal matching aid is added to states' own resources, the average difference in states' funding ability drops from 22.7 percent to 18.1 percent. This represents a 20 percent reduction of aggregate differences in states' funding ability.[15] After the receipt of federal matching aid, differences in states' funding abilities ranged from 26 percent below the national average for California and New York to 179 percent above for Alaska.

[14]The average difference in states' funding ability is calculated by comparing each state's funding ability with the average funding ability of all states and calculating the average difference (both positive and negative), weighting each state by its number of people in poverty.

[15]In an absolute sense, the federal matching rate enhances the funding ability of all states. By comparing each state's funding ability with the average funding ability for all states, our measure of funding ability is a relative, rather than an absolute, measure of differences in funding ability. As a consequence, while states with low funding ability receiving a relatively low federal match are helped in an absolute sense, in a relative sense they move farther below a new, higher national average funding ability, resulting in relatively larger differences in states' funding ability.

Figure 1: States' Funding Ability Compared with the National Average, without and with the Value of Federal Matching Aid Added



Sources: HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Note: GAO analysis of data from HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Funding Ability of 21 States Moves Farther from Average State's Funding Ability after Federal Match Is Added

The aggregate 20 percent reduction of differences in states' funding ability under the formula masks the effect of the formula on individual states. For example, as shown in figure 1, consistent with the formula's goals, the one-quarter of states with the lowest funding ability before the match move closer to the average state's funding ability after the value of the federal match is added.[16] In total, 30 states move closer to the national average after adding the federal match. However, as the right panel of figure 1 shows, adding the value of federal matching aid often has inconsistent effects. For example, including the value of federal matching aid moves Alaska's and Utah's funding ability farther above, rather than closer to, the national average funding ability. This happens because PCI does not adequately reflect that these two states have fewer people in poverty than the national average. In addition, Utah has lower-than-average costs to provide health care services. The current formula actually moves 21 states farther above or below the average:

- Four of the 21 states—California, Florida, Hawaii, and New York—have below-average funding ability before federal matching aid is added and move farther below the average after federal matching aid is added. These 4 states have approximately 31 percent of the nation's people in poverty. For example, California's funding ability drops from 15 percent below the average to 26 percent below the average and New York's funding ability drops from 12 percent below the average to 26 percent below the average. These two states thus rank last in terms of state funding ability after the value of federal matching aid is added.
- Thirteen states that have above-average funding ability before adding the value of federal matching aid move farther above the average after it is added.[17] For example, Utah's funding ability is 73 percent above the national average before the federal match is added but increases to 155 percent above the national average after the match.
- Of the 4 remaining states, 3—Idaho, Maine, and North Dakota—have below-average funding ability before the match is added and above-

[16]In decreasing order of funding ability before adding the value of the federal match, these states are Tennessee, Kentucky, Oklahoma, Montana, Arizona, South Carolina, Louisiana, District of Columbia, Alabama, Arkansas, West Virginia, New Mexico, and Mississippi.

[17]The states, listed from highest to lowest funding ability, are Alaska, Utah, Wisconsin, Indiana, Wyoming, Iowa, Kansas, Missouri, Nebraska, Vermont, Ohio, Oregon, and South Dakota.

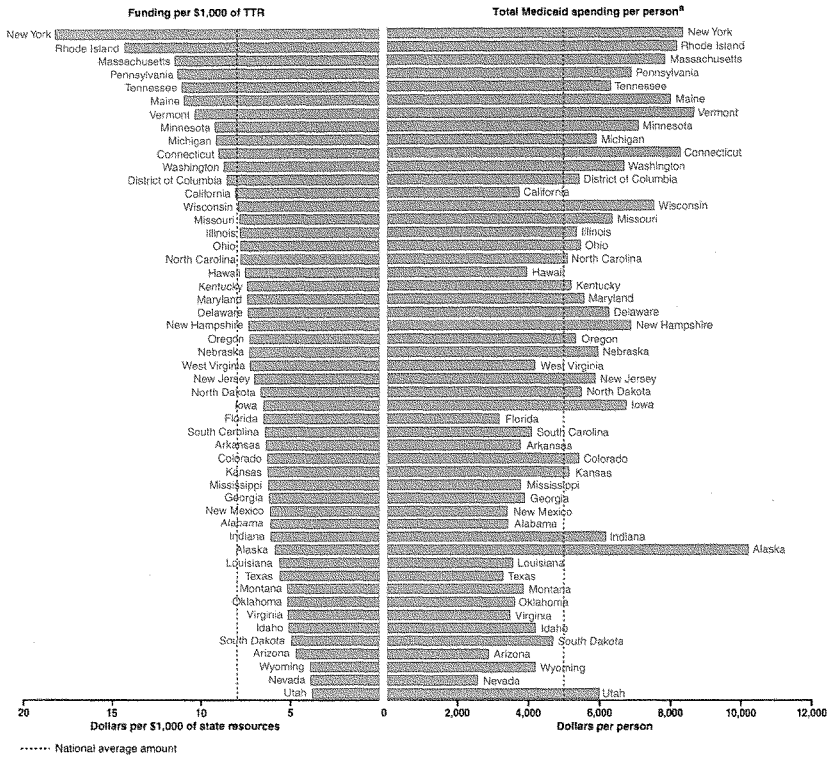
average funding ability after the match is added. For the fourth state—Rhode Island—the reverse is true: Rhode Island has above-average funding ability before the match and below-average funding ability after the match is added.

Many States Devoting the Same Proportion of Their Own Resources to Medicaid Cannot Spend Comparable Amounts per Person

States commit widely varying proportions of their own financial resources to fund Medicaid benefits. For example, in fiscal year 2000, New York devoted $18.16 per $1,000 of its TTR toward its Medicaid program,[18] roughly 5 times the proportion of resources that Utah devoted ($3.74 per $1,000) (see left panel of fig. 2). States' Medicaid cost-adjusted spending per person in poverty varies as well. For example, Alaska's combined federal and state spending was over $10,000 per person in poverty, while Nevada's spending was approximately $2,500 per person in poverty (see right panel of fig. 2).

[18]The TTR amount used in these calculations is a 3-year average, 1996-98.

Figure 2: Proportion of State Resources Devoted to Medicaid, Compared with Total (State plus Federal) Medicaid Spending, Fiscal Year 2000



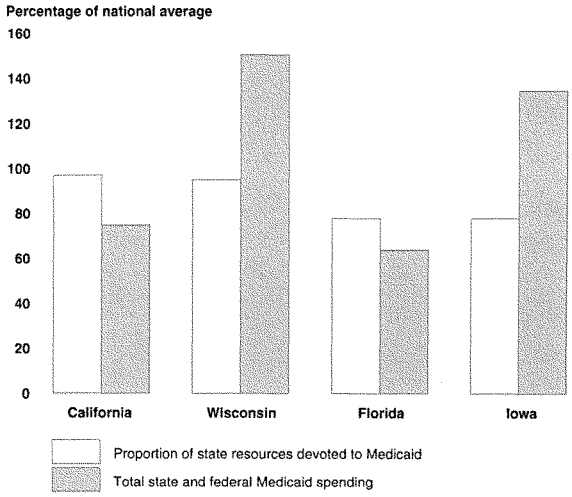
Sources: HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Note: GAO analysis of data from HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

[a]Medicaid spending per person is total spending (state and federal) per person in poverty after adjusting for cost differences related to age and geographic location.

Because the federal matching formula does not fully eliminate differences in states' funding ability, states devoting similar proportions of their own resources to Medicaid cannot spend the same amounts per person in poverty, cost adjusted, with federal matching aid factored in. In addition, because the formula further increases the already high funding ability of some states and decreases the low funding ability of others, these spending differences can be quite large. For example, in fiscal year 2000, both California and Wisconsin devoted roughly the same proportion of their own resources to fund program benefits—about $8 per $1,000 of taxable resources—which was close to the national average ($8.37) proportion of resources states devoted to Medicaid that year. However, the current formula moved California's below-average funding ability farther below the national average and increased Wisconsin's above-average funding ability farther above. This occurred because Wisconsin receives a high federal match despite its relatively high funding ability, whereas California receives a low federal match despite its relatively low funding ability. Once federal matching aid was factored in, with their nearly identical funding effort, Wisconsin is enabled to spend more than twice what California could spend per person in poverty—$7,532 compared with $3,731. Similarly, Florida and Iowa each devoted $6.48 per $1,000 in state resources toward their Medicaid programs. After adding the federal match, Iowa could spend $6,729 per person in poverty, cost adjusted, while Florida could spend just $3,160 per person. (See fig. 3.)

Figure 3: Proportion of State Resources Devoted to Medicaid Compared with Program Spending per Person in Poverty, as a Percentage of the National Average, Selected States, Fiscal Year 2000



Sources: HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Notes: Spending per person in poverty includes cost adjustments for differences in age and geographic location. GAO analysis of data from HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Use of PCI and 50 Percent Floor Inhibits Formula's Ability to Further Narrow Differences in States' Funding Ability

Two factors prevent the Medicaid formula from further reducing differences in states' funding ability. First, PCI—the single measure used to establish federal matching rates—is not a comprehensive measure of state resources and is a poor proxy for the size of and cost to serve a state's population in poverty. Second, special statutory provisions, including the minimum 50 percent federal matching rate, give several states with already high funding ability a higher federal matching rate than they would receive without these provisions.

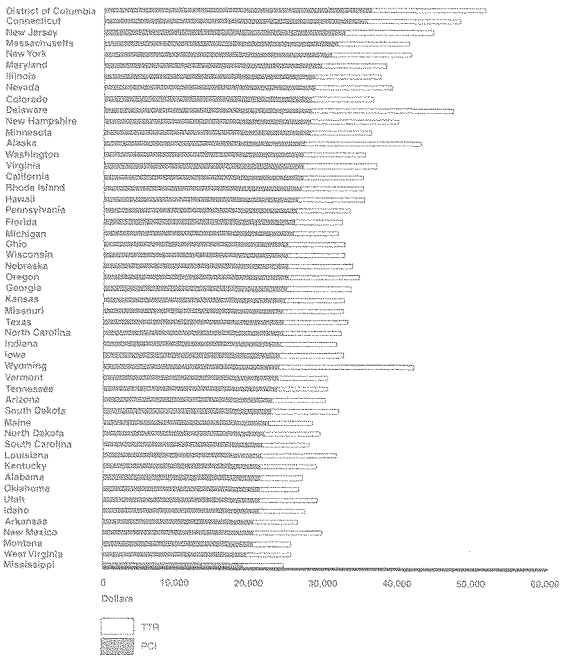
PCI Is Not a Comprehensive Measure of States' Resources and Is a Poor Proxy for the Size of and Cost to Provide Services to Their People in Poverty

PCI is an inadequate measure of states' funding ability because it is an incomplete measure of states' resources, it is a poor proxy for the size of a state's population in poverty, and it does not take into account differences in the cost of providing health care services to people in poverty. As an indicator of state resources, PCI measures income received by state residents, such as wages, rents, and interest income, but it does not include other sources of income potentially subject to state taxation, such as corporate income produced within the state but not received by state residents. For example, PCI especially understates the taxable resources in energy-exporting states, such as Alaska and Wyoming, and in states that house numerous corporate headquarters, such as Delaware.

By comparison, because TTR comprises the income included in PCI as well as income from other sources, such as corporate income and capital gains, states' TTR exceeds PCI by about 32 percent nationwide.[19] As shown in figure 4, which compares states' TTR with PCI, states whose resources are particularly poorly represented by PCI include the District of Columbia, Delaware, Alaska, and Wyoming.

[19]For a discussion of TTR, see Department of the Treasury, Office of Economic Policy, *Treasury Methodology for Estimating Total Taxable Resources, TTR* (Washington, D.C.: Oct. 1, 1998; revised November 2002). http://www.treas.gov/offices/economic-policy/resources/index.html?IMAGE.X=28\&IMAGE.Y=9 (See "Summary of Current Methodology for Estimating TTR") (downloaded June 4, 2003).

Figure 4: States' per Capita TTR and PCI, 1996-98

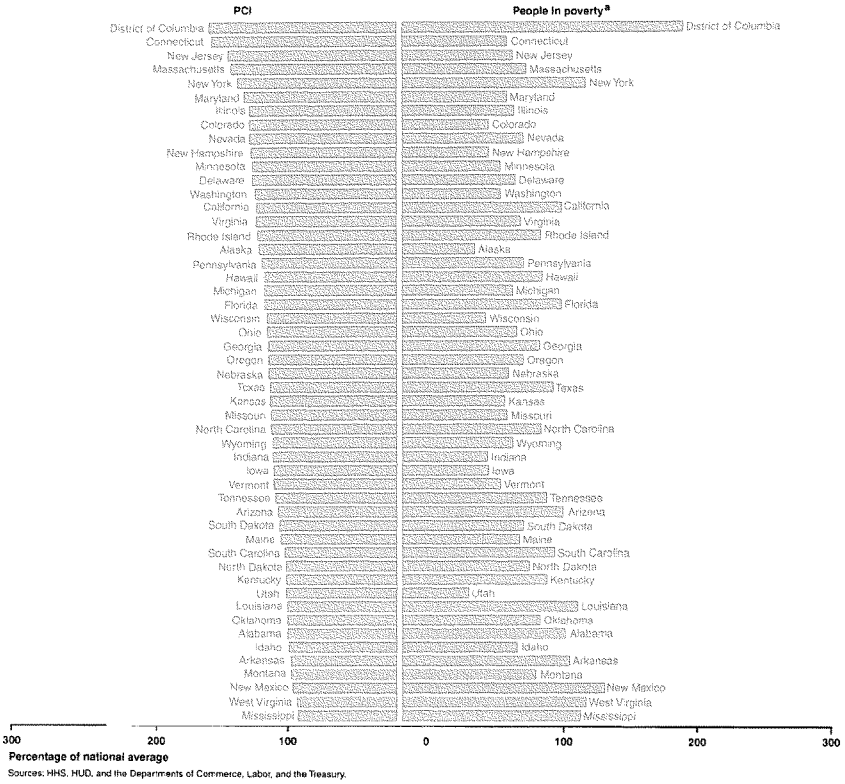


Sources: Departments of Commerce and the Treasury.

Notes: TTR comprises the income included in PCI as well as income from other sources, such as corporate income and capital gains. GAO analysis of data from the Departments of Commerce and the Treasury.

Using PCI to measure the size of a state's low-income population assumes that the lower a state's PCI, the greater its population in poverty. However, two states with similar PCIs may differ widely in their percentages of people in poverty. In addition, PCI is not a good proxy for the differences in the cost of providing health care services that are related to the ages of the population served and the geographic area in which services are provided. Persons who are elderly typically use health care services at higher rates than adults and children and therefore cost more to serve. Two states with low PCIs may have very different proportions of elderly persons potentially eligible for Medicaid. In addition, costs to provide health care services vary widely depending on geographic location because wages and other costs of office space vary regionally. For example, the District of Columbia and Connecticut have similar PCIs, but the share of the District's population in poverty is more than twice Connecticut's. Health care costs also are 10 percent higher in the District than in Connecticut. (Fig. 5 compares state rankings by PCI and by people in poverty, adjusted for cost differences related to age and geographic location.)

Figure 5: Comparison of States' PCIs with Their People in Poverty, Cost Adjusted



Sources: HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

Note: GAO analysis of data from HHS, HUD, and the Departments of Commerce, Labor, and the Treasury.

*People in poverty refers to people with incomes at or below the FPL, adjusted for cost differences related to age and geographic location.

Minimum Federal Match Generally Helps States That Already Have High Funding Ability

Because of the 50 percent floor, 11 states received higher federal matching rates in fiscal year 2002 than they would have if their rates had been based only on their PCI. Two others—Alaska and the District of Columbia—received special federal matching rates set in statutes that gave them higher matching rates than they would have received solely on the basis of PCI.[20] (See table 1.)

[20]Alaska's current higher matching rate was authorized by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to address inadequacies in the national calculation and establish more equitable matching rates for the state. Pub. L. No. 106-554, App. F, § 706, 114 Stat. 2763, 2763A-577. The District of Columbia's higher matching rate was authorized by the Balanced Budget Act of 1997 at the time comprehensive policy changes realigning the financial relationship between the District and federal government also were enacted. Pub. L. No. 105-33, § 4725 and tit. XI, 111 Stat. 251, 518 and 712.

Table 1: States Benefiting from Minimum Matching Rate Provisions, Fiscal Year 2002, and Their Matching Rates without the Minimums

	Numbers in percent			
State	Funding ability without federal match (as a percentage of national average)	Minimum federal matching rate	Federal matching rate without minimum match	Percentage point difference
Alaska	219	57.38	53.01	-4.37
New Hampshire	179	50.00	47.36	-2.64
Connecticut	176	50.00	14.99	-35.01
Colorado	165	50.00	46.22	-3.78
Delaware	162	50.00	48.13	-1.87
New Jersey	160	50.00	29.60	-20.40
Maryland	143	50.00	42.32	-7.68
Minnesota	143	50.00	48.03	-1.97
Illinois	131	50.00	46.09	-3.91
Massachusetts	131	50.00	32.27	-17.73
Nevada	126	50.00	46.62	-3.38
New York	88	50.00	37.14	-12.86
District of Columbia	71	70.00	12.99	-57.01

Source: HHS.

Notes: States are listed in decreasing order of funding ability. GAO analysis of data from HHS.

Eleven of these 13 states (all except the District of Columbia and New York) had above-average funding ability in fiscal year 2002. Their receipt of a higher federal matching rate than they would have received without statutory minimums increases the overall differences in funding ability among the states. Connecticut and New Jersey benefit the most from the statutory minimums, receiving—as a result of the 50 percent floor—matching rates that are 35 and 20 percentage points higher, respectively, than the rates they would have received based solely on their PCI. Receiving a higher matching rate than what the formula provides on the basis of PCI enables these states to spend more on program benefits per person in poverty than states with less funding ability that devote a higher percentage of their resources to funding program benefits.

The statutory minimums benefit the District of Columbia and New York by providing them a higher matching rate than they would otherwise have. Because these two states have below-average funding ability, the minimum matching provisions have the effect of moving them closer to the funding ability of the average state and thus help to reduce overall differences in

funding ability among the states. For example, New York's funding ability without the value of federal matching aid added is 12 percent below the average funding ability; with the value of federal matching aid added, its funding ability is farther from the average funding ability—26 percent below the average. Without the floor, New York's matching rate would be 37 percent, rather than 50 percent. Therefore, the 50 percent minimum brings New York's funding ability closer to the average funding ability than it would be with the matching rate it would receive without the minimum.

Comments from External Reviewers

We received comments on our draft report from two external reviewers who have Medicaid formula expertise. The reviewers generally agreed with our analysis and provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to appropriate congressional committees and will make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please call me at (202) 512-7118 or Jerry Fastrup at (202) 512-7211. Major contributors to this report include Richard Horte, Robert Dinkelmeyer, Michael Williams, Elizabeth T. Morrison, and Michael Rose.

Sincerely yours,

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Legislative History and Description of the Matching Formula

This appendix summarizes the legislative history that led to the use of per capita income (PCI) in the Medicaid matching formula and describes how matching rates are calculated.

Legislative History of the Medicaid Formula

The current formula is an outgrowth of variable rate matching formulas first discussed by Congress in the late 1940s. Senate reports accompanying the Social Security Act Amendments of 1946 first articulated, in the case of public assistance, the rationale for a variable rate matching formula based on state PCI:

> Federal grants-in-aid for public assistance are intended to help in aiding the aged and blind persons and dependent children in all parts of the country and to some extent to equalize the financial burden throughout the Nation. . . . The present 50 percent basis of Federal participation does not recognize differences in the ability of States to finance public assistance, nor does it recognize the greater incidence of poverty in States with low economic resources. To assist their needy people, the low income States must make greater tax effort than States with larger resources where relatively fewer persons are in need.[1]

The Social Security Amendments of 1958 established a PCI-based variable rate matching formula, with certain maximums, for public assistance and reimbursement of medical providers. Under this formula, federal matching rates ranged from a minimum of 50 percent for high-income states to a maximum of 65 percent for low-income states.[2] The Social Security Amendments of 1960 increased the maximum matching rate from 65 percent to 80 percent.[3]

[1]S. Rep. No. 79-1862, at 15 (1946), *reprinted in* 1946 U.S.C.C.A.N. 1510, 1525. In conference, a variable rate was adopted, but not one based on state PCI. S. Conf. Rep. No. 79-2724, at 8 (1946), *reprinted in* 1946 U.S.C.A.N.N. 1552, 1555.

[2]Pub. L. No. 85-840, § 505, 72 Stat. 1013, 1050. Before this, payments to medical providers were reimbursed up to a certain maximum dollar amount at a uniform rate of 50 percent for all states. S. Rep. No. 85-2388, at 39 (1958), *reprinted in* 1958 U.S.C.C.A.N. 4212, 4259.

[3]Pub. L. No. 86-778, sec. 601(f), § 6(c), 74 Stat. 924, 991.

Current Medicaid Matching Formula

When Medicaid was created in 1965, it (1) was structured as an open-ended entitlement for eligible low-income individuals without limits on the maximum dollar amount subject to reimbursement, as in predecessor programs;[4] (2) increased the federal government's total nationwide share financed from 50 to 55 percent; and (3) raised the maximum federal matching rate from 80 to 83 percent.[5] The statutory matching formula, known as the Federal Medical Assistance Percentage (FMAP), used for calculating matching rates is

$$\text{FMAP} = 1.00 - 0.45\left(\frac{\text{State PCI}}{\text{U.S. PCI}}\right)^2$$

The current matching formula is calibrated with a 0.45 "multiplier." The value of the multiplier determines the percentage of a state's Medicaid spending for which the state is responsible. For example, using the 0.45 multiplier, a state with a PCI equal to the U.S. average would receive a federal matching rate of 55 percent (1 - 0.45 = 0.55). A smaller multiplier of 0.40 would raise the federal matching rate for all states and would raise the matching rate for a state with the national average PCI from 55 percent to 60 percent, whereas a higher multiplier of 50 percent would reduce the federal matching rate for a state with average PCI from 55 percent to 50 percent.

Relative PCI is intended to represent states' funding ability, which is a combination of states' resources and states' people in poverty.[6] Consistent with this intent, squaring PCI has the effect of making PCI appear in the formula twice, thus reflecting both state resources and people in poverty. Squaring PCI magnifies the difference between the state's and the national average PCI. For example, if a state's PCI is 90 percent of the national average, the squared value of its relative PCI would be 81 percent (0.9 x 0.9 = 0.81), resulting in a federal matching rate of 64 percent (that is, 1.00 - 0.45 x 0.81 = 0.64), rather than the 60 percent rate the state would receive if relative income was not squared (that is, 1.00 - 0.45 x 0.9 = 0.60). If PCI

[4]Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121, § 1905(b), 79 Stat. 286, 344.

[5]See U.S. General Accounting Office, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27 (Washington, D.C.: Mar. 9, 1983) for a more complete description of the legislative history of the Medicaid formula.

[6]A state's *relative* PCI is its PCI when expressed as a percentage of the U.S. average PCI.

were a good proxy for people in poverty, squaring would be appropriate since squaring would reflect the effect on states' funding ability of both resources and people in poverty. However, to the extent that PCI does not accurately reflect state resources and people in poverty, squaring magnifies this inaccuracy.

The Department of Health and Human Services (HHS) is responsible for calculating matching rates under the formula. HHS is required to calculate matching rates 1 year before the fiscal year in which they are effective, using a 3-year average of the most recently available PCI data reported by the Department of Commerce. Thus, fiscal year 2003 matching rates were calculated at the beginning of fiscal year 2002 using a 3-year average of PCI for 1998 through 2000. Publicly announcing matching rates a year in advance of their use allows states time to make program changes in response to changes in the rate at which the federal government will reimburse eligible program costs. However, the combination of a 1-year lag between the computation of state matching rates and their implementation, coupled with the fact that a 3-year average of PCI is used, also means that the distribution of states' matching rates reflects economic conditions that existed several years earlier. Federal matching rates for fiscal years 2002 through 2004 are shown in table 2.

Table 2: Medicaid Matching Rates for Fiscal Years 2002-2004

	Fiscal year		
State	2002	2003	2004
Alabama	70.45	70.60	70.75
Alaska	57.38	58.27	58.39
Arizona	64.98	67.25	67.26
Arkansas	72.64	74.28	74.67
California	51.40	50.00	50.00
Colorado	50.00	50.00	50.00
Connecticut	50.00	50.00	50.00
Delaware	50.00	50.00	50.00
District of Columbia	70.00	70.00	70.00
Florida	56.43	58.83	58.93
Georgia	59.00	59.60	59.58
Hawaii	56.34	58.77	58.90
Idaho	71.02	70.96	70.46
Illinois	50.00	50.00	50.00
Indiana	62.04	61.97	62.32
Iowa	62.86	63.50	63.93
Kansas	60.20	60.15	60.82
Kentucky	69.94	69.89	70.09

State	Fiscal year 2002	2003	2004
Louisiana	70.30	71.28	71.63
Maine	66.58	66.22	66.01
Maryland	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00
Michigan	56.36	55.42	55.89
Minnesota	50.00	50.00	50.00
Mississippi	76.09	76.62	77.08
Missouri	61.06	61.23	61.47
Montana	72.83	72.96	72.85
Nebraska	59.55	59.52	59.89
Nevada	50.00	52.39	54.93
New Hampshire	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00
New Mexico	73.04	74.56	74.85
New York	50.00	50.00	50.00
North Carolina	61.46	62.56	62.85
North Dakota	69.87	68.36	68.31
Ohio	58.78	58.83	59.23
Oklahoma	70.43	70.56	70.24
Oregon	59.20	60.16	60.81
Pennsylvania	54.65	54.69	54.76
Rhode Island	52.45	55.40	56.03
South Carolina	69.34	69.81	69.86
South Dakota	65.93	65.29	65.67
Tennessee	63.64	64.59	64.40
Texas	60.17	59.99	60.22
Utah	70.00	71.24	71.72
Vermont	63.06	62.41	61.34
Virginia	51.45	50.53	50.00
Washington	50.37	50.00	50.00
West Virginia	75.27	75.04	75.19
Wisconsin	58.57	58.43	58.41
Wyoming	61.97	61.32	59.77

Source: HHS.

Note: GAO compiled data from HHS.

Appendix II: Methodology

This appendix describes our methodology for measuring the extent to which the current Medicaid matching formula reduces differences in states' funding abilities and the data, and their sources, we used to measure the elements of states' funding ability. While we considered alternative indicators of state resources, people in poverty, and the cost of health care, and we chose those indicators we believed were most appropriate, we did not perform an exhaustive comparative analysis of other potential indicators, nor did we attempt to develop new indicators.

Measuring States' Funding Ability

Funding Ability from State Resources

We defined a state's ability to fund Medicaid services as the economic resources a state is potentially able to tax to fund its Medicaid program relative to the number of persons with incomes below the federal poverty level (FPL), adjusted for the cost of providing health care to them. Specifically, we took into account differences in the utilization of health care services by children, adults, and the elderly, and we developed an index for the differences in the cost of health care personnel and the cost of medical facilities and supplies used to provide the services.

We calculated state funding ability according to the following formula:

$$\begin{pmatrix}\text{State Funding}\\ \text{Ability From}\\ \text{Own Resources}\end{pmatrix}_{state} = \left(\frac{Y_{state}}{P_{state} * c_{state}}\right)$$

where

Y = State resources potentially subject to state taxation

P = People with incomes below the FPL, adjusted for differences in service utilization by children, adults, and the elderly

c = Index of the cost of factors in the provision of health care services (e.g., health care personnel, medical facilities, and supplies).

We explain later in this appendix how we adjusted the counts of people in poverty for differences in service utilization and in the cost of personnel, facilities, and supplies.

State Funding Ability with the Value of Federal Matching Aid Added

Federal matching aid, in effect, adds to a state's ability to fund program costs from its own resources. For example, when federal matching aid pays for half the cost of a state's program, it effectively doubles that state's ability to fund program services. The higher the federal matching rate, the more federal matching aid contributes to a state's ability to fund Medicaid services. In general, a state's funding ability after the value of its federal matching aid is added can be determined using the following formula:

$$\left(\begin{array}{l}\text{Medicaid Funding Ability}\\ \text{with Federal Matching Aid}\end{array}\right)_{state} = \left(\frac{1}{1-FMAP_{state}}\right)\left(\frac{Y_{state}}{P_{state} * c_{state}}\right)$$

where

FMAP = State's federal matching rate

Y = State resources potentially subject to state taxation

P = People with incomes below the FPL, adjusted for differences in service utilization by children, adults, and the elderly

c = Index of the cost of factors in the provision of health care services (e.g., health care personnel, medical facilities, and supplies).

The first term after the equals sign represents the multiple by which a state's matching rate increases the state's funding ability. For example, if a state receives a federal match of 75 percent, its funding ability is increased by a factor of 4 [(1/(1 - 0.75) = 4].

Calculating the Reduction of Differences in States' Funding Ability

To measure the effect of the current formula in reducing differences in states' funding ability, we compared differences between each state's funding ability before and after the value of federal matching aid is added and calculated the percentage reduction in these differences. In performing these calculations, we measured each state's funding ability relative to the average funding ability of all states. The resulting indexes of states' funding abilities provide a means of comparing relative differences

in states' ability to fund their Medicaid programs. We used the weighted absolute mean deviation as a quantitative measure of differences in states' funding ability. This statistic is a measure of average differences in states' funding ability. It is calculated by taking the absolute value of each state's index of relative funding ability and computing the arithmetic average of these differences, using the following formula:

$$\text{Mean Absolute Deviation} = \frac{\sum_{s=1}^{51} w_s \cdot \left| X_s - X_{AVG} \right|}{\sum_{s=1}^{51} w_s}$$

where

X_s = A state's funding ability index

X_{AVG} = Weighted average of all states' funding ability indexes

w_s = A state's weighting factor (people in poverty).

In calculating the mean absolute deviation, we took into account differences in the potential size of state programs by using the number of people living in poverty in each state.

We chose the mean absolute deviation rather than the more commonly used weighted standard deviation because the latter, by squaring differences between each state's funding ability and the national average funding ability, gives much greater weight to states at the extreme ends of the distribution of states' funding abilities, resulting in a measure that is more sensitive to extreme values and thus less likely to reflect the norm.

We calculated the mean absolute deviation in states' funding ability both without and with the value of federal matching aid added. Calculating the percentage change in the two mean absolute deviations measures the extent to which the current formula reduces differences in states' funding ability. For example, if the current formula completely eliminated differences in states' funding ability, total funding ability of all states would equal the average of all states, and the mean absolute deviation would be zero, representing a 100 percent reduction in differences in states' funding ability (the maximum possible). Alternatively, if the formula had no effect in reducing differences in states' funding ability, the

mean absolute deviation in states' funding ability with the value of federal matching aid taken into account would be the same as the mean absolute deviation in states' funding ability from their own resources. In this case, there would be no change in the mean absolute deviation, meaning that the matching formula had no effect in reducing relative differences in states' funding ability.

Table 3 shows each state's index of Medicaid funding ability without and with the value of its federal matching aid.

Table 3: States' Ability to Fund Program Services without and with the Value of Fiscal Year 2000 Federal Matching Aid Added

	State Medicaid funding ability (percentage of national average)	
State	(1) Without federal matching aid[a]	(2) With FY 2000 federal matching aid
Alabama	65	89
Alaska	219	279
Arizona	73	98
Arkansas	61	94
California	85	74
Colorado	165	138
Connecticut	176	147
Delaware	162	136
District of Columbia	71	102
Florida	81	78
Georgia	96	101
Hawaii	98	84
Idaho	94	131
Illinois	131	110
Indiana	148	162
Iowa	147	166
Kansas	126	132
Kentucky	79	112
Louisiana	72	101
Maine	95	117
Maryland	143	120
Massachusetts	131	110
Michigan	111	103
Minnesota	143	123
Mississippi	54	97
Missouri	123	130
Montana	73	119

State	State Medicaid funding ability (percentage of national average) (1) Without federal matching aid[a]	(2) With FY 2000 federal matching aid
Nebraska	122	131
Nevada	126	106
New Hampshire	179	150
New Jersey	160	134
New Mexico	55	88
New York	88	74
North Carolina	94	105
North Dakota	92	132
Ohio	111	112
Oklahoma	76	112
Oregon	111	117
Pennsylvania	108	98
Rhode Island	101	92
South Carolina	73	102
South Dakota	105	152
Tennessee	80	91
Texas	86	93
Utah	173	255
Vermont	121	134
Virginia	125	108
Washington	141	123
West Virginia	56	92
Wisconsin	150	153
Wyoming	147	174

Sources: HHS and the Departments of Commerce, Labor, and the Treasury.

Note: GAO calculations are based on data from HHS and the Departments of Commerce, Labor, and the Treasury.

[a]Funding ability without federal matching aid was calculated using an average of state taxable resources for 1996 through 1998.

The mean absolute deviation of states' funding ability before taking into account the value of federal matching aid (column 1 of table 3) yielded an average difference in states' relative funding ability of 22.7 percent. The mean absolute deviation in states' funding ability after taking into account the value of federal matching aid (column 2 of table 3) yielded an average difference of 18.1 percent. This difference represents a 20 percent overall reduction in differences in states' funding ability as a result of adding federal matching aid.

Measuring State Resources

As the indicator of state resources in the formula, PCI includes income received by state residents ("personal income"), such as wages, rents, and interest income, but excludes other important taxable income. For example, PCI excludes corporate income not received as income by state residents, such as undistributed corporate profits and dividends received by people who reside out-of-state. An ideal resources measure would count all income that states are able to tax. Even certain types of income that states exempt from taxation or tax at preferential rates should be counted as potentially taxable income because these enhance taxpayers' ability to pay all taxes levied in the state.

We used Total Taxable Resources (TTR), as reported by the Department of the Treasury, to measure state resources because it comprises the income included in PCI as well as income from other sources, such as corporate income and capital gains, and thus it is a more comprehensive indicator of income than PCI alone.[1] TTR includes personal income received by state residents as well as income produced within a state but received by individuals who reside out-of-state (which is considered a portion of the Gross State Product (GSP)). As indicated in table 4, nationwide, the TTR measure of income is 32 percent larger than PCI.

Table 4: Comparison of PCI with TTR, 3-Year Averages, 1996-98

State	PCI	TTR per capita	Percentage difference
Alabama	$21,194	$26,884	27
Alaska	27,001	42,755	58
Arizona	22,842	29,947	31
Arkansas	20,310	26,324	30
California	26,867	35,057	30
Colorado	28,014	36,340	30
Connecticut	35,507	48,047	35
Delaware	27,872	47,020	69
District of Columbia	36,067	51,503	43
Florida	25,756	32,267	25
Georgia	24,756	33,364	35
Hawaii	26,209	35,220	34
Idaho	21,035	27,399	30

[1]Another possible measure of a state's resources is the Representative Tax System developed by the Advisory Commission on Intergovernmental Relations. We did not use this measure in our analysis because data on this measure are not available on an annual basis.

State	PCI	TTR per capita	Percentage difference
Illinois	28,442	37,421	32
Indiana	23,902	31,493	32
Iowa	23,785	32,282	36
Kansas	24,388	32,456	33
Kentucky	21,241	28,774	35
Louisiana	21,272	31,520	48
Maine	22,376	28,205	26
Maryland	29,305	38,019	30
Massachusetts	31,448	41,141	31
Michigan	25,608	31,558	23
Minnesota	27,773	35,996	30
Mississippi	18,981	24,480	29
Missouri	24,251	32,314	33
Montana	20,291	25,436	25
Nebraska	24,832	33,481	35
Nevada	28,383	38,887	37
New Hampshire	27,776	39,760	43
New Jersey	32,492	44,438	37
New Mexico	20,296	29,533	46
New York	30,661	41,470	35
North Carolina	24,194	32,076	33
North Dakota	21,577	29,298	36
Ohio	24,897	32,450	30
Oklahoma	21,152	26,412	25
Oregon	24,817	34,477	39
Pennsylvania	26,096	33,239	27
Rhode Island	26,589	35,002	32
South Carolina	21,444	27,809	30
South Dakota	22,603	31,700	40
Tennessee	23,450	30,323	29
Texas	24,201	32,931	36
Utah	21,135	29,010	37
Vermont	23,487	30,344	29
Virginia	26,869	36,788	37
Washington	26,912	35,271	31
West Virginia	19,400	25,379	31
Wisconsin	24,863	32,456	31
Wyoming	23,615	41,920	78
United States	$25,949	$34,299	32

Source: Departments of Commerce and the Treasury.

Notes: Data reflect 3-year averages of TTR and PCI. GAO analysis of data from the Departments of Commerce and the Treasury.

While TTR is a more comprehensive measure of state resources than PCI, recent definitional changes to GSP and state personal income (SPI) data made by the Bureau of Economic Analysis (BEA) may have implications for the methodology used by the Department of the Treasury to calculate TTR. For example, BEA has changed its treatment of the value of services provided by government-owned fixed assets that are now included in GSP and benefit payments of government employee pension plans, which are now excluded from SPI. Since the Treasury initially developed the TTR methodology, it has not reported why definitional changes made by BEA should or should not be reflected in TTR. In the case of the changes to government pension plans, the Treasury has reported it is currently studying whether they necessitate any modifications to the TTR methodology.

Measuring People in Poverty and the Costs to Provide Them Program Services

To measure people in poverty, we adjusted the Bureau of the Census's estimates of people in households with incomes at or below the FPL for (1) differences in the cost of providing health care services to children, adults, and the elderly (to account for the higher health care costs for the elderly) and (2) geographic differences in the cost of providing health care services (such as wages and salaries of health care professionals and the rental cost of medical facilities).[2]

Measuring the Number of People in Poverty

We obtained estimated counts of people living in poverty from the Bureau of the Census's Current Population Survey (CPS). Because the CPS sample sizes for individual states are especially small when disaggregated by age cohorts, they are subject to greater statistical error than a sample representing all age groups. To improve the accuracy of these estimates, we averaged poverty counts over the 5-year period 1995 through 1999. We used the FPL as a basis for making cross-state comparisons of the number of people in poverty. (See table 5.)

[2]We have excluded disproportionate share hospital (DSH) payments from this analysis. These hospitals receive additional Medicaid reimbursement because they serve a disproportionate number of Medicaid and other low-income patients. We have excluded these payments from our analysis because the federal government uses a different distribution formula from the regular Medicaid program.

Table 5: Distribution of Population in Poverty, by Age Group, 5-Year Averages, 1995-99

State	Official poverty count	Percentage who are		
		Children[a]	Adults[b]	Elderly[c]
Alabama	684,401	44	44	11
Alaska	52,434	47	50	3
Arizona	773,651	49	44	7
Arkansas	418,593	43	44	14
California	5,213,675	48	46	6
Colorado	356,379	42	52	6
Connecticut	307,435	46	44	10
Delaware	73,643	47	43	11
District of Columbia	111,071	43	46	12
Florida	2,040,854	41	47	12
Georgia	1,024,452	47	44	9
Hawaii	138,433	42	49	9
Idaho	166,135	49	44	7
Illinois	1,335,576	49	42	9
Indiana	485,926	39	50	10
Iowa	273,851	44	47	9
Kansas	275,646	45	44	12
Kentucky	568,739	41	48	10
Louisiana	811,417	47	44	10
Maine	132,323	39	47	14
Maryland	437,917	42	44	14
Massachusetts	653,754	43	46	11
Michigan	1,064,367	47	43	10
Minnesota	437,201	46	43	11
Mississippi	518,149	45	44	11
Missouri	554,936	42	46	11
Montana	143,838	46	47	7
Nebraska	176,270	42	44	13
Nevada	181,524	46	45	9
New Hampshire	91,519	42	45	12
New Jersey	680,727	39	47	13
New Mexico	411,507	51	42	8
New York	2,945,784	45	45	10
North Carolina	931,440	42	46	12
North Dakota	81,831	44	44	12
Ohio	1,308,010	46	45	9
Oklahoma	486,474	42	47	11
Oregon	410,697	45	49	7

State	Official poverty count	Percentage who are		
		Children[a]	Adults[b]	Elderly[c]
Pennsylvania	1,322,801	42	47	12
Rhode Island	107,019	40	43	17
South Carolina	539,744	46	42	12
South Dakota	86,713	45	42	13
Tennessee	784,910	43	47	10
Texas	3,149,475	48	44	9
Utah	163,467	51	44	5
Vermont	61,026	42	49	9
Virginia	686,279	39	48	13
Washington	584,612	43	50	7
West Virginia	299,257	36	50	14
Wisconsin	448,444	46	45	10
Wyoming	57,957	45	45	9
United States	35,052,282	45	45	10

Source: Department of Commerce.

Note: Percentages may not add to 100 across age groups because of rounding.

[a]Population under age 21 with income at or below the FPL.

[b]Population aged 21 to 64 with income at or below the FPL.

[c]Population aged 65 and over with income at or below the FPL.

Adjusting Poverty Counts for Differences in Costs to Serve Children, Adults, and the Elderly

Official poverty counts are not a good proxy for the low-income population because they do not take into account the higher cost of serving elderly individuals. For example, elderly individuals represented 27 percent of Medicaid beneficiaries in fiscal year 2000, the latest year for which data are available. However, because they are more intensive users of the health care system and utilize more expensive long-term care services, elderly persons accounted for 66 percent of all Medicaid spending that year.

To account for differences in costs to serve each group, we weighted the numbers of children, adults, and the elderly. We calculated Medicaid spending per beneficiary for each age group nationwide, then compared spending per beneficiary for each age group with average spending per beneficiary for all age groups. We used a 5-year average of Medicaid spending per beneficiary derived from data reported by the Centers for Medicare & Medicaid Services (CMS) for fiscal years 1995 through 1999. The results suggest that, nationwide, elderly beneficiaries utilize health

care services at about two-and-one-half times the rate of the average Medicaid beneficiary, and children utilize services at less than half the rate of the average beneficiary. (See the cost weight index column in table 6.)

Table 6: Weights for Age Groups to Reflect Cost Differences and Medicaid Program Participation

Age group	Average annual spending per beneficiary	Cost weight (index)[a]	Average participation rate (index)[b]	Adjusted cost weight[c]
Elderly (aged 65 or older)	$9,005	2.5	1.4	3.5
Adults (aged 21-64)	$4,729	1.3	0.7	1.0
Children (under age 21)	$1,483	0.4	1.2	0.5
All groups	$3,532	1.0	1.0	1.0

Sources: Department of Commerce and HHS.

Note: GAO analysis of data from the Department of Commerce for 1995 through 1999 and data from HHS for 1994 through 1998.

[a]Index is spending per recipient for each age group divided by average spending per recipient for all age groups.

[b]Index is the percentage of people in each age group receiving Medicaid benefits, expressed as a ratio to the average of all groups.

[c]Calculated by multiplying the cost weight index by the participation rate index.

To adjust for differences in program participation across age groups, we compared the number of Medicaid beneficiaries by age group with the number of people in poverty. We compared these counts with the national average participation rates for all Medicaid beneficiaries. We calculated the adjusted cost weight by multiplying the cost weight index by the average participation rate index. We calculated a weighted count of people in poverty for each state by applying the adjusted cost weights in the last column of table 6 to poverty counts by age group, according to the following formula:

$$\begin{pmatrix}\text{Weighted}\\ \text{Poverty}\\ \text{Count}\end{pmatrix} = 3.5 \begin{pmatrix}\text{Number in}\\ \text{Poverty}\\ \text{Over}\\ \text{Age 65}\end{pmatrix} + 1.0 \begin{pmatrix}\text{Number in}\\ \text{Poverty}\\ \text{Aged 21 to 64}\end{pmatrix} + 0.5 \begin{pmatrix}\text{Number in}\\ \text{Poverty Under}\\ \text{Age 21}\end{pmatrix}$$

In table 7, the columns representing official poverty rates report the percentage of people in poverty based on the official government poverty

statistics reported by the Bureau of the Census. The age-weighted columns are the percentages of people in poverty after weighting children, adults, and the elderly. Comparing the percentages in the official poverty rate columns with the percentages after age-weighting illustrates the effect of differences in utilization rates by age cohort. For example, Florida's official poverty rate is revised upward from 14.0 percent to 15.3 percent when weighted for age differences. Similarly, the District of Columbia's poverty rate increases from about 21.1 percent to about 22.7 percent after weighting.[3]

[3]The age and health care use cost-adjusted poverty rates in table 7 will be discussed in the next section, in which we describe the cost adjustments made for differences in medical care costs.

Table 7: Comparison of Official and Cost-Adjusted Poverty Rates, 5-Year Averages, 1995-99

	Official poverty rate		Age-weighted poverty rate		Age and health care use cost-adjusted poverty rate	
State	Percentage of people in poverty	Percentage of U.S. poverty rate	Percentage in poverty	Percentage of U.S. poverty rate	Percentage in poverty	Percentage of U.S. poverty rate
Alabama	15.9	122	16.9	128	16.0	121
Alaska	8.2	63	6.9	52	7.2	54
Arizona	16.5	126	15.2	115	15.7	119
Arkansas	16.3	125	18.3	138	16.4	124
California	15.9	122	14.2	108	15.7	118
Colorado	9.0	69	8.4	63	8.5	64
Connecticut	9.3	71	9.4	71	10.4	78
Delaware	9.9	75	10.2	77	11.1	84
District of Columbia	21.1	162	22.7	172	27.7	209
Florida	14.0	108	15.3	116	15.6	118
Georgia	13.6	104	13.6	103	13.4	102
Hawaii	11.6	89	11.9	90	13.7	104
Idaho	13.6	104	12.6	95	11.3	85
Illinois	11.1	85	11.0	83	11.0	83
Indiana	8.4	64	8.9	68	8.3	63
Iowa	9.6	74	9.7	73	8.5	64
Kansas	10.7	82	11.4	86	10.1	76
Kentucky	14.7	112	15.4	117	14.2	107
Louisiana	19.0	145	19.2	145	17.1	130
Maine	10.7	82	12.5	94	11.6	87
Maryland	8.6	66	9.9	75	10.3	78
Massachusetts	10.7	82	11.3	86	12.1	92
Michigan	10.8	83	10.9	83	10.9	82
Minnesota	9.2	71	9.8	74	9.7	73
Mississippi	18.9	145	19.6	149	17.5	132
Missouri	10.4	80	11.2	85	10.3	78
Montana	16.0	123	15.0	114	13.1	99
Nebraska	10.6	81	11.8	90	10.4	79
Nevada	10.5	80	10.4	79	11.9	90
New Hampshire	7.7	59	8.5	64	8.5	64
New Jersey	8.5	65	9.6	73	10.8	82
New Mexico	22.6	173	21.2	161	19.8	150
New York	16.1	123	16.5	125	17.9	136
North Carolina	12.8	98	13.9	105	13.6	103
North Dakota	13.0	99	14.1	106	12.4	94
Ohio	11.6	89	11.7	88	11.2	85
Oklahoma	14.8	114	15.7	119	13.5	102
Oregon	12.5	95	11.8	89	11.9	90
Pennsylvania	11.1	85	12.0	91	11.9	90

State	Official poverty rate		Age-weighted poverty rate		Age and health care use cost-adjusted poverty rate	
	Percentage of people in poverty	Percentage of U.S. poverty rate	Percentage in poverty	Percentage of U.S. poverty rate	Percentage in poverty	Percentage of U.S. poverty rate
Rhode Island	11.2	86	13.6	103	13.6	103
South Carolina	14.3	109	15.1	114	14.9	113
South Dakota	12.3	94	13.5	102	12.0	90
Tennessee	14.2	109	14.5	110	14.2	107
Texas	16.1	124	15.8	119	14.8	112
Utah	7.9	61	7.0	53	6.5	49
Vermont	10.3	79	10.6	80	9.6	73
Virginia	10.4	79	11.8	89	11.6	88
Washington	10.4	79	10.0	75	9.7	73
West Virginia	17.0	131	20.1	152	18.0	136
Wisconsin	8.6	66	8.7	66	8.3	62
Wyoming	12.0	92	12.1	91	10.8	82
United States	13.1	100	13.2	100	13.2	100

Sources: HHS, and the Departments of Commerce, Housing and Urban Development (HUD), and Labor.

Note: GAO analysis of data from HHS, HUD, and the Departments of Commerce and Labor.

Adjusting Poverty Counts for Differences in the Cost of Providing Health Care Services

The cost of providing health care services is affected by three factors: (1) the cost of the personnel who provide the services (wages, for example), (2) the rental cost of facilities in which the services are provided, and (3) the cost of medical equipment and supplies.

We used the average wage per worker in the health industry (Standard Industrial Classification (SIC) code 8000), produced by the Bureau of Labor Statistics (BLS), to measure the cost of personnel for 1996 through 1998. The BLS cost data cover personnel in a wide variety of settings, including offices, clinics, hospitals, and medical and dental laboratories, as well as health care providers who work for home health agencies.

To measure the cost of facilities through which services are delivered, we used apartment rents as reported by the Department of Housing and Urban Development (HUD) because data on commercial office space rental rates in the health sector of the economy were not available. Apartment rental rates were an appropriate alternative because the same factors that affect the cost of office space (for example, population density and income) affect housing rental rates, and apartment rental rates are likely to more closely mimic office space costs than would owner-occupied housing units. In addition, data are available for apartment

rentals by the size of the unit, which allowed us to take size differences into account.

Data on the geographic differences in the cost of medical equipment and supplies were not readily available. Because medical equipment and supplies generally are purchased in national markets, we assumed that the costs of these items do not vary across states.

We calculated an index of health industry wage rates and apartment rents (our proxy for the rental cost of medical facilities). For medical supplies, we used a cost index of 1.0 for all states to reflect the assumption that these costs do not vary across states. We then combined the three factors into an overall index of the cost of health care services by state, weighting each factor on the basis of its respective proportion of the total cost of health care services. Personnel costs represent the greatest share of health care costs, as much as 75 percent of total costs, according to one study.[4] We constructed our cost index conservatively by reducing the personnel cost weight to 60 percent. We applied a cost weight of 30 percent for medical equipment and supplies and other miscellaneous costs that are assumed to be the same across states. The remaining 10 percent is the cost weight for rent. Using these cost weights is likely to understate cross-state cost differences.

Nineteen states had health care costs estimated to be at least 10 percent above or below the national average. The states with costs 10 percent or more above the national average were California, Connecticut, the District of Columbia, Hawaii, Nevada, and New Jersey. States with lower costs tended to be southern or midwestern states. (See table 8.)

[4]Gregory Pope, *Adjusting the Alcohol, Drug Abuse, and Mental Health Services Block Grant for Allocations for Poverty Population and Cost of Service* (Needham, Mass.: Health Economics Research, Inc., Mar. 30, 1990).

Table 8: Wage, Rent, and Health Care Cost Indexes, by State

State	Percentage of national average		
	Wage index (3-year averages, 1996-98)	Rent index (FY 2000)	Health care cost index
Alabama	96	70	95
Alaska	104	124	105
Arizona	106	98	103
Arkansas	**88**	**67**	**89**
California	**112**	**127**	**110**
Colorado	101	107	101
Connecticut	**113**	**125**	**110**
Delaware	114	104	109
District of Columbia	**131**	**133**	**122**
Florida	103	100	102
Georgia	100	91	99
Hawaii	**119**	**139**	**115**
Idaho	**87**	**75**	**90**
Illinois	100	104	100
Indiana	92	82	93
Iowa	**83**	**74**	**87**
Kansas	**85**	**77**	**89**
Kentucky	92	69	92
Louisiana	**87**	**72**	**89**
Maine	90	88	93
Maryland	105	113	104
Massachusetts	106	131	107
Michigan	101	93	100
Minnesota	99	93	99
Mississippi	**87**	**66**	**89**
Missouri	91	74	92
Montana	**82**	**77**	**87**
Nebraska	**84**	**77**	**88**
Nevada	**122**	**110**	**114**
New Hampshire	99	112	100
New Jersey	**114**	**134**	**112**
New Mexico	92	81	93
New York	109	132	109
North Carolina	99	84	98
North Dakota	**85**	**71**	**88**
Ohio	96	85	96
Oklahoma	**83**	**69**	**86**
Oregon	101	99	101
Pennsylvania	99	94	99

State	Percentage of national average: Wage index (3-year averages, 1996-98)	Rent index (FY 2000)	Health care cost index
Rhode Island	99	108	100
South Carolina	101	79	99
South Dakota	**85**	**77**	**89**
Tennessee	100	76	98
Texas	92	90	94
Utah	90	95	93
Vermont	85	97	91
Virginia	98	98	99
Washington	94	106	97
West Virginia	**88**	**66**	**90**
Wisconsin	95	85	95
Wyoming	87	76	90
United States	100	100	100

Sources: HHS, HUD, and the Department of Labor.

Notes: States in bold have health care costs estimated to be 10 percent or more above or below the national average. GAO analysis of data from HHS, HUD, and the Department of Labor.

Calculating States' Ability to Fund Medicaid Services without and with Value of Federal Matching Aid Added

We compared states' ability to fund Medicaid services without and with the value of federal matching aid added. Column 1 of table 9 shows states' funding ability: states' TTR per person in poverty adjusted for differences in the cost of providing them health care services. Column 2 shows states' effective fiscal year 2000 federal matching rates used in the analysis[5] and column 3 shows the resulting "multipliers" (i.e., 1/(1 - FMAP)) that reflect the effect of federal matching on states' funding ability. Funding ability with federal aid is shown in column 4.

[5]To calculate effective matching rates we divided each state's federal matching aid by its total Medicaid spending, net of DSH and certain other costs.

Table 9: States' Funding Ability without and with the Value of Fiscal Year 2000 Federal Matching Aid Added

State	(1) Funding ability from state resources (dollars per person in poverty)[a]	(2) Effective FY 2000 FMAP (percentage)	(3) FMAP multiplier	(4) Funding ability with federal matching aid (col. 1 x col. 3)
Alabama	$169,683	69.64	3.29	$558,840
Alaska	570,409	67.26	3.05	1,742,447
Arizona	189,505	69.19	3.25	615,081
Arkansas	158,718	73.11	3.72	590,165
California	222,437	52.06	2.09	463,963
Colorado	429,969	50.08	2.00	861,380
Connecticut	459,835	50.02	2.00	920,046
Delaware	422,823	50.20	2.01	848,991
District of Columbia	184,951	70.93	3.44	636,309
Florida	211,705	56.60	2.30	487,803
Georgia	251,548	60.01	2.50	628,961
Hawaii	256,566	51.03	2.04	523,891
Idaho	244,092	70.29	3.37	821,587
Illinois	341,369	50.15	2.01	684,770
Indiana	386,661	61.84	2.62	1,013,136
Iowa	382,676	63.14	2.71	1,038,320
Kansas	328,243	60.09	2.51	822,538
Kentucky	205,683	70.62	3.40	700,085
Louisiana	187,290	70.37	3.38	632,139
Maine	246,614	66.31	2.97	732,052
Maryland	374,141	50.18	2.01	750,931
Massachusetts	342,550	50.13	2.01	686,922
Michigan	289,686	55.17	2.23	646,136
Minnesota	372,580	51.69	2.07	771,185
Mississippi	140,227	76.89	4.33	606,653
Missouri	320,009	60.58	2.54	811,740
Montana	190,431	74.49	3.92	746,413
Nebraska	319,214	61.00	2.56	818,427
Nevada	327,582	50.45	2.02	661,158
New Hampshire	467,893	50.08	2.00	937,274
New Jersey	417,976	50.07	2.00	837,128
New Mexico	142,227	74.19	3.87	551,081
New York	229,337	50.11	2.00	459,721
North Carolina	244,355	62.61	2.67	653,542
North Dakota	238,866	70.97	3.45	822,897
Ohio	289,509	58.72	2.42	701,375
Oklahoma	198,643	71.63	3.53	700,263
Oregon	288,765	60.42	2.53	729,556
Pennsylvania	281,796	53.84	2.17	610,540

State	(1) Funding ability from state resources (dollars per person in poverty)[a]	(2) Effective FY 2000 FMAP (percentage)	(3) FMAP multiplier	(4) Funding ability with federal matching aid (col. 1 x col. 3)
Rhode Island	264,602	53.77	2.16	572,326
South Carolina	189,300	70.18	3.35	634,851
South Dakota	274,528	71.07	3.46	948,856
Tennessee	209,859	63.19	2.72	570,142
Texas	224,158	61.54	2.60	582,883
Utah	452,178	71.65	3.53	1,595,085
Vermont	315,610	62.39	2.66	839,259
Virginia	325,551	51.90	2.08	676,811
Washington	367,374	52.08	2.09	766,584
West Virginia	145,611	74.80	3.97	577,734
Wisconsin	392,390	58.88	2.43	954,178
Wyoming	383,724	64.63	2.83	1,084,827
United States	$260,851	56.83	2.32	$624,935

Sources: HHS and the Department of the Treasury.

Notes: Calculations were done with unrounded numbers, not the rounded numbers shown in the table. GAO analysis of data from HHS and the Department of the Treasury.

[a]Funding ability without federal matching aid was calculated using an average of TTR for 1996 through 1998.

Comparing Proportion of States' Resources Devoted to Medicaid with Their Total Spending per Person in Poverty

The data used to show the relationship between a state's effort to fund Medicaid benefits from its own financial resources and its total Medicaid spending per person in poverty, shown in figure 2, are displayed in table 10.

Table 10: Proportion of State Resources Devoted to Medicaid per $1,000 of TTR Compared with Total Medicaid Spending per Person in Poverty, Cost Adjusted, Fiscal Year 2000

State	State financial resources per $1,000 of TTR	Total Medicaid spending per person in poverty
Alabama	$6.08	$3,397
Alaska	5.84	10,178
Arizona	4.64	2,851
Arkansas	6.35	3,747
California	8.04	3,731
Colorado	6.26	5,391
Connecticut	8.99	8,274
Delaware	7.35	6,242
District of Columbia	8.51	5,417
Florida	6.48	3,160
Georgia	6.15	3,869
Hawaii	7.51	3,935
Idaho	5.07	4,166
Illinois	7.79	5,332
Indiana	6.07	6,153
Iowa	6.48	6,729
Kansas	6.23	5,127
Kentucky	7.40	5,179
Louisiana	5.59	3,533
Maine	10.93	7,999
Maryland	7.38	5,544
Massachusetts	11.43	7,849
Michigan	9.12	5,895
Minnesota	9.20	7,094
Mississippi	6.19	3,757
Missouri	7.82	6,345
Montana	5.13	3,826
Nebraska	7.26	5,941
Nevada	3.83	2,533
New Hampshire	7.32	6,864
New Jersey	7.00	5,857
New Mexico	6.12	3,370
New York	18.16	8,347
North Carolina	7.77	5,075
North Dakota	6.64	5,467
Ohio	7.77	5,449
Oklahoma	5.12	3,586
Oregon	7.26	5,299
Pennsylvania	11.29	6,891

State	State financial resources per $1,000 of TTR	Total Medicaid spending per person in poverty
Rhode Island	14.27	8,170
South Carolina	6.40	4,061
South Dakota	4.92	4,671
Tennessee	11.04	6,296
Texas	5.58	3,252
Utah	3.74	5,964
Vermont	10.32	8,661
Virginia	5.10	3,455
Washington	8.71	6,679
West Virginia	7.22	4,170
Wisconsin	7.89	7,532
Wyoming	3.85	4,171
United States	$8.37	$5,056

Sources: HHS and the Departments of Commerce, Housing and Urban Development, and the Treasury.

Note: GAO analysis of data from HHS and the Departments of Commerce, Housing and Urban Development, and the Treasury.

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American Enterprise Institute for Public Policy Research

AEI

No. 2 • January 2007

Health Policy Outlook

The Medicaid Commission Report: A Dissent

By Robert B. Helms

While instructive, the Medicaid Commission's final report on reforming the program does not fully address its deficiencies, particularly the problems with the formula which allocates Medicaid funds to states. Worthwhile reforms would direct Medicaid funds to the states and populations that need them most.

In May 2005, Secretary of Health and Human Services Michael O. Leavitt established the Medicaid Commission, chartering it "to advise the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way."[1] The commission issued two reports. The first, submitted on September 1, 2005, provided recommendations for achieving short-term budget savings. A final report, suggesting how best to reform the program, was released on December 29, 2006.[2]

There were fifteen voting members and fifteen non-voting members who met on nine occasions. During these meetings the commission members were given extensive briefings and heard public testimony from health-care experts and Medicaid recipients. In many cases, the latter group consisted of disabled recipients, or the parents, spouses, and caregivers struggling to care for them. Their common refrain was, "Don't cut our Medicaid benefits!" The public testimony was often emotional, so much so that it was sometimes difficult to see how it would help the commission address the financial and management problems presented by the experts. Still, the stories told by recipients and caregivers did affect the commission's view of Medicaid's basic problems. The public and expert testimony showed that Medicaid plays a crucial role in helping state and local governments take care of the most vulnerable people in our society. But it also reminded us that the present Medicaid program does a poor job of taking care of these individuals, and that it cannot be sustained without substantial reform. These observations delineated the basic issues that we struggled with for a year and a half.

I voted for the final report and for all of the specific proposals approved by the commission. The final recommendations provide a helpful, overdue road map to achieve useful reforms of the program. I submitted a dissent to the report, however, because I believe that the commission did not address an important aspect of the current program that is the root cause of many of Medicaid's problems.[3] This *Health Policy Outlook* is intended to provide background and a thorough rationale for my dissent.

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The Origin of the Problem

Medicaid has an ill-conceived—and now outdated—method for calculating the level of federal financial support for the states. Until this issue is addressed, and a fairer and more equitable method is developed, Medicaid will continue to be plagued by problems, including:

- poor targeting of resources to help the poorest and most disadvantaged members of our communities
- uncontrolled growth of federal and state spending
- rampant fraud and abuse
- incentives for states to use questionable accounting schemes to increase federal funding
- federal subsidy formulas that are unable to sufficiently respond to changing economic conditions
- intensifying adversarial relationships between the states and the federal government that reduce the chance of political compromise on policy reforms

Since its passage in 1965, the Medicaid program has operated as a joint effort between the federal and state governments to finance health care for a population that has grown to 55 million people.[4] It is an open-ended entitlement program financed with both federal and state funds, with the federal government financing approximately 57 percent of Medicaid's total cost of $301 billion in FY 2005.[5] The amount of federal money that flows to the states is partially determined by the Federal Medical Assistance Percentage (FMAP).[6] This formula compares each state's per-capita personal income to the national per-capita personal income and is designed to provide larger federal subsidies to states with relatively low incomes.[7]

The FMAP formula determines only the percentage rate at which the federal government matches claims submitted by the states. The total amount of federal funds flowing to each state is also a function of the number of claims that a state submits to cover the costs of providing mandatory and optional benefits for the populations the program can serve. This feature of Medicaid financing—allowing each state to determine how much it will spend and obligating the federal government to match what the state chooses to spend—has been a popular feature of the program. For the politicians who designed the original program, it met the national objective of subsidizing medical coverage for those with low incomes while allowing each state great flexibility to choose its own level of desired and affordable support, threading the twin political needles of compassion and federalism.[8] In a recent AARP report, Vic Miller and Andy Schneider point out that the original objective of the FMAP was to:

- enable states of varying means to provide roughly equivalent benefits to their Medicaid-eligible populations
- increase and decrease federal matching payments to states to reflect changed economic circumstances
- target states with higher concentrations of individuals in poverty[9]

However, they also point out that these objectives were not fully realized, concluding: "The FMAP formula, most analysts agree, does not adequately reflect the different fiscal capacities of the states and does not take into account the circumstances of states with high concentrations of poor citizens."[10]

The following data on the distribution of federal Medicaid payments illustrates how the current financing system has failed to allocate federal subsidies to the poorest people in our population. In 2004, the most recent year of available Medicaid data from the Center for Medicare & Medicaid Services (CMS), federal Medicaid payments to the states ranged from a low of $233 *million* to Wyoming to a high of $21.4 *billion* to New York. Since there are large differences in the population of the various states, however, federal expenditures are more easily compared when expressed on a per-population basis, independent of a state's Medicaid enrollment policies. This can be achieved by dividing federal Medicaid payments to each state by the number of poor and near-poor people in poverty (below 125 percent of the federal poverty line). These per-capita federal payments in FY 2004 ranged from $1,736 in Nevada to $6,780 in Maine.[11]

As illustrated in figures 1 and 2 on the next page, data for all states reveal that there is a negative relationship between the per-capita amount of federal funds flowing to the states and the amount of poverty in the states—that is, as a general tendency, the poorer the state, the less federal money that state receives.

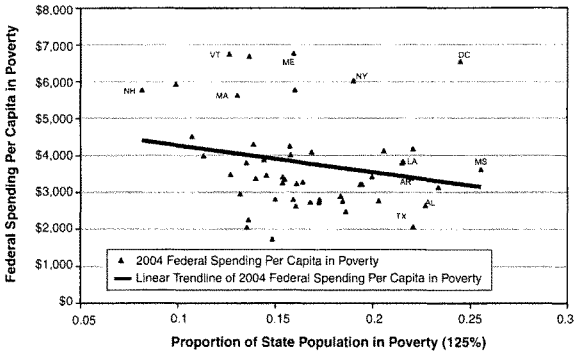
The official audited data for state Medicaid expenditures for FY 2005 have not yet been released by CMS. Preliminary data represented in figure 2, however, indicate an almost identical pattern.

Once again, there is an inverse correlation between poverty rates and federal per-capita Medicaid reimbursement. States with the highest poverty rates—such as Alabama, Louisiana, and Mississippi—received much lower Medicaid payments per-capita than did wealthier states like New York and several New England states.[12]

Not only can the wealthier states afford to spend more on Medicaid, the open-ended process of obligating the federal government to match what the state chooses to spend creates an incentive for states to increase Medicaid spending relative to all other priorities. When a state is forced to cut budget expenditures, the FMAP procedure gives the state an incentive not to cut matched expenditures relative to unmatched state expenditures. With a minimum matching rate of 50 percent, a state would have to cut total Medicaid expenditures by $2 in order to cut state expenditures by $1, thereby foregoing $1 in federal funds.[13] This incentive results in a ratchet effect in state Medicaid budgets, since Medicaid expenditures tend to rise in times of plenty but are rarely reduced when states must cut back.[14]

FIGURE 1

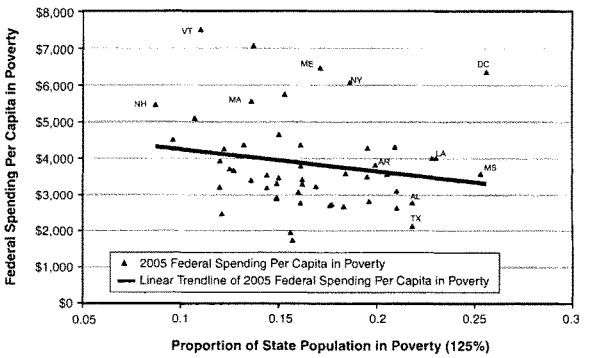
2004 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY



SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details.

FIGURE 2

2005 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY

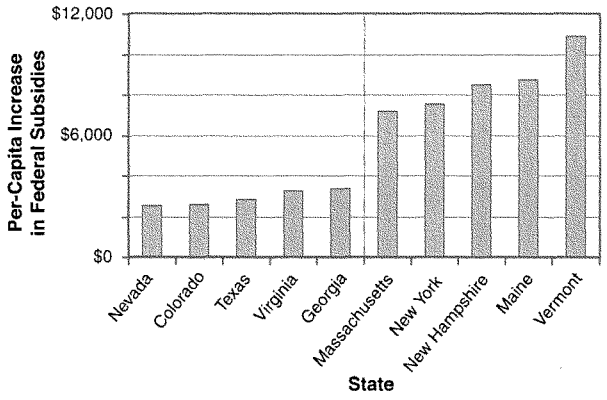


SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details. FY 2005 Medicaid data are preliminary and are subject to change. These data were obtained directly from CMS.

Another way to look at the effects of current Medicaid payment policy is to examine which states have increased their federal payments the most over an extended period. I obtained records of federal Medicaid payments to the states for FY 1970 and expressed them on a per-capita basis using the number of people at or below 100 percent of poverty in 1970.[15] Figure 3 shows the five states with the smallest increases and the five states with the largest increases for the period 1970–2005.[16] Again, New York and several New England states have consistently taken greater advantage of the open-ended federal assistance formula than the poorer Southern states.

Clearly, the FMAP procedure is not successfully achieving the original objective of Medicaid: targeting federal assistance toward the states with the greatest share of poverty. Poorer states today are falling behind as wealthier states are collecting a disproportionate share of federal Medicaid dollars.

FIGURE 3
STATES WITH SMALLEST AND LARGEST INCREASES IN FEDERAL MEDICAID SUBSIDIES, 1970–2005



SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 15 for calculation details.

The FMAP formula also poorly counteracts the effects of changes in a state's economic activity. The measurement of a state's per-capita personal income does not accurately track changes in state economic activity. The three-year averaging procedure, as well as delayed updating, results in a substantial lag in FMAP adjustments.[17] If a state's economy begins to decline relative to other states, it may take from three to six years for FMAP to adjust to this change.

The FMAP procedure of Medicaid financing has been criticized by policy analysts and government agencies for decades.[18] This criticism comes from analysts representing a wide spectrum of policy-oriented and philosophical approaches to health policy, proving that this debate is not just a matter of government budgets. The perverse incentives created by this method of financing would be present at any level of spending. In addition to the AARP report, a recent report from the National Academy of State Health Plans refers to the Medicaid "tug of war" and calls for steps to improve the fiscal integrity of federal financing.[19] The authors of the report point out that the FMAP procedure creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to attempt to control these schemes—hence the "tug of war." Numerous analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather than consider reforms that would be in the best interest of those Medicaid is intended to serve.

Moving Forward

How should Medicaid be reformed? The literature on reform suggests myriad approaches for using alternative population or economic variables in the formula and for making the formula more responsive to changing economic conditions in the states.[20] But before these approaches can be considered, it is important to understand how the existing system affects the politics of Medicaid reform. Overcoming the political obstacles to reform is daunting. The problem is linked to the incentives created by the open-ended nature of the current payment policy and the fact that no state, regardless of its economic status, receives less than a 50 percent match from the federal government. Any state willing to spend more on expanding optional benefits or covering optional beneficiaries—including beneficiaries with higher incomes—will only incur at most half the additional cost of the expansion. This creates strong pressure for a state to increase its Medicaid program and, as argued earlier, creates disincentives to control these costs. In this situation, any discussion of a change in the FMAP formula is seen as a possible threat to the open-ended flow of federal funds to the state. Any formula based on estimates of the number of poor, disabled, or aged—or any new idea to reduce the marginal reward for additions to the program—can easily be turned into a table of winners and losers by a good number cruncher.[21]

This is not conducive to any serious discussion of reform. The result is a continuation of the decade-long political stalemate. As pointed out by Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam,

CMS is on the defensive in trying to issue new regulations to control state-level program expansions.[22] Meanwhile, Congress tries to control costs by passing new controls on payment rates to providers and suppliers.[23] This dissonance between state incentives to expand eligibility and federal attempts to control expenditures can only be expected to intensify in future years as the population ages and the cost of caring for the disabled puts more pressure on federal and state budgets.[24] As in any system that relies primarily on price controls and government rationing, Medicaid beneficiaries will have access to fewer providers and will experience decreases in the quality of care.

The commission was presented with ample evidence that the millions of poor, aged, and disabled people—the types of people that the commission heard from during the public testimony—were not being well-served in most states. This does not mean that some individuals with higher incomes or less-severe disabilities could not be helped by some subsidies. It only illustrates the basic problem with all welfare programs: targeting assistance to those most in need without creating incentives for others to take advantage of the program. With limited resources, how does the government target resources to the neediest? The present Medicaid program seems designed to do just the opposite, shifting resources toward citizens who live in wealthier states.

Medicaid advocacy groups and others who seem to have a near-religious belief in the concept of open-ended entitlements will not like to hear it, but I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years. The annual projections of the future costs of entitlements from the Congressional Budget Office show that the three largest entitlement programs (Social Security, Medicare, and Medicaid) will grow from 42.9 percent of federal spending in 2006 to 49.3 percent by 2015, and to 52.6 percent by 2020.[25] While these projections are driven more by Medicare than by Medicaid or Social Security, such growth in total entitlement spending will require either large tax increases or drastic reductions in all categories of discretionary spending (education, defense, and infrastructure, for example)—a highly improbable outcome. Likelier is a continuing Congressional effort to control Medicaid expenditures by imposing more controls on payments and benefits, an approach that will only exacerbate today's access and quality problems.

I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years.

The extensive literature on Medicaid reform offers a number of ideas about how to correct these perverse incentives and to ensure that the program focuses on helping the poorest and most vulnerable of our citizens. My preferred approach would be to block-grant the program and force Congress to decide how much money it wants to devote to Medicaid compared to all other budget priorities. With that amount determined, a revised formula based on the number of disabled, aged, and low-income people in each state could be used to distribute the money to the states. A relatively long transition period (at least ten years) would give the states ample time to redesign their programs. However, since block-granting any entitlement program is now out of favor, my second choice would be to reform the current FMAP formula to target the poorest and most disabled beneficiaries and to reduce the matching percentage for program extensions beyond current mandatory coverage for those with higher incomes or for optional benefits.[26] The latter approach would reduce the incentive for states to game the system, and it would give them reasons to find better ways to help the neediest. Meanwhile, this approach would also leave states free to expand their own programs if they wish to do so.

In 1996, Congress reformed welfare programs when it became clear that they were not achieving their intended purposes.[27] It is now time to do the same for Medicaid. The Medicaid Commission's recommendations to increase state flexibility constitute a good start, but they will not correct the massive, perverse incentives now disrupting the program. Until these issues are addressed, the budgetary and policy deficiencies that led to the formation of this commission will continue to fester.

AEI research assistant Jonathan Stricks and editorial assistant Evan Sparks worked with Mr. Helms to edit and produce this Health Policy Outlook.

Notes

1. The final report, the charter, and a complete record of commission meetings can be found at http://aspe.hhs.gov/medicaid/ (accessed December 30, 2006).

2. U.S. Department of Health and Human Services, Medicaid Commission, *Final Report and Recommendations: Medicaid Commission*, December 29, 2006, available at http://aspe.hhs.gov/medicaid/122906rpt.pdf (accessed January 3, 2007).

3. Ibid., 28–29.

4. For an historical account of the passage of Medicaid in 1965 and its early years, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974).

5. U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, preliminary Form CMS-64 data (FY 2005) on federal and state total net expenditures.

6. For a more complete description of the FMAP formula and procedures, see Vic Miller and Andy Schneider, "The Medicaid Matching Formula: Policy Considerations and Options for Modification" (research report 2004-09, Public Policy Institute, AARP, Washington, DC, September 2004), available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf (accessed December 30, 2006).

7. The formula for each state is: FMAP equals 100 percent – the state's share. The state's share equals 0.45 × (state's per-capita income ÷ national per-capita income)^2. Multiplying by 0.45 was to ensure that a state with per-capita income near the national average received a 55 percent federal subsidy. The ratio of a state's per-capita income to national per-capita income was squared as a way of providing a larger federal subsidy to the poorest states. The calculation each year uses state and national per-capita income over a three-year period. Congress has established special matching rates for Alaska and the District of Columbia. No state receives less than a 50 percent matching rate, a rule that protected thirteen states and the District of Columbia in FY 2004. See Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 9. Congress has also provided enhanced matching rates for limited periods of time and for specific purposes.

8. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, DC: AEI Press, 1983), 30–41.

9. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 16.

10. Ibid., 17. See especially the authors' list of studies backing up this conclusion in their note 40.

11. The calculations were made by the author based on data from two government sources. Federal Medicaid payments to the states is from CMS, Form CMS-64 data (FY 2004), available at www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage (accessed December 30, 2006); the number of people at or below 125 percent of poverty in each state, and the percent of poverty in each state, is from the Census Bureau, CPS, 2004, available at http://pubdb3.census.gov/macro/032005/pov/new46_100125_01.htm (accessed December 30, 2006).

12. New York, Massachusetts, Vermont, Connecticut, and New Hampshire received average per-capita federal payments of $5,848 in FY 2004; Texas, Alabama, Louisiana, Arkansas, and Mississippi received average per-capita payments of $2,585.

13. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 3–4. The higher the federal matching rate, the greater the penalty for cutting a matched expenditure. A state with a 70 percent match would have to reduce total Medicaid spending by $3.33 in order to save the state $1.

14. The FMAP procedure also affects a state's incentive to fight fraud and abuse in Medicaid since it affects the relative return from controlling fraud and abuse in matched—versus unmatched—state programs. If a state saves $1 by investing in fraud and abuse control in Medicaid, it must share 50 percent or more (depending on the state's matching rate) of the savings with the federal government. If a state saves $1 by reducing fraud and abuse in an unmatched program, all of the $1 savings accrue to the state.

15. With the help of John Klemm in the CMS Office of the Actuary, we obtained records of FY 1970 federal medical assistance payments for the forty-eight states (Alaska and Arizona had no such payments in 1970) from the Medicaid Financial Management Reports (Form OA-41). We then computed per-capita federal expenditures by dividing by the number of people at or below 100 percent of poverty in those states in FY 1970 and FY 2005. The mean absolute increase in per-capita federal payments for all forty-eight states was $5,075. Arkansas ($5,502) was the only Southern state with an increase above the mean.

16. The District of Columbia's matching rate is set by Congress at 70 percent, and therefore is not based on the FMAP formula. Excluding the District from the five states with the largest increases moves Massachusetts into the top five states.

17. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 4. See also their references to studies of the impact of Medicaid on state economic activity in their note 9.

18. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs*. Miller and Schneider list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending," memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO,

"Medicaid Formula: Differences in Funding Ability among States Often Are Widened," GAO-03-620, July 2003. For more recent criticisms, see John R. Graham, "Taming the Medicaid Monster," *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); and Pamela Villarreal, "Federal Medicaid Funding Reform" (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006).

19. Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

20. See Vic Miller and Andy Schneider, "The Medicaid Matching Formula"; and the references in note 18 of this *Health Policy Outlook*.

21. For examples, see Vic Miller and Andy Schneider, "The Medicaid Matching Formula," tables 6 and 8–14; GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97, October 2006; and Donald B. Marron, "Medicaid Spending Growth and Options for Controlling Costs" (statement of the CBO acting director before the U.S. Senate Special Committee on Aging, Washington, DC, July 13, 2006).

22. Sonya Schwartz *et al.*, *Moving beyond the Tug of War*, 6.

23. See Andy Schneider, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33" (Center on Budget and Policy Priorities, Washington, DC, September 8, 1997), available at www.cbpp.org/908mcaid.htm (accessed December 29, 2006).

24. See Donald B. Marron, "Medicaid Spending Growth and Options for Controlling Costs," especially at table 4.

25. Congressional Budget Office, *The Long-Term Budget Outlook*, December 2005, scenario 1, calculated from data in supporting tables.

26. Medicaid Commission, *Final Report and Recommendations*, viii. The "scaled match" that the commission recommends be studied in recommendation C-3 would be a step in this direction.

27. See Douglas J. Besharov and Peter Germanis, "Welfare Reform and the Caseload Decline," in *Family and Child Well-Being after Welfare Reform*, ed. Douglas J. Besharov (New Brunswick, NJ: Transaction, 2003), 35–65, available at www.aei.org/book431/.

Mr. CASSIDY. Secondly, Madame Secretary, I have got young children so what I am about to say just strikes me. Sometimes it seems like opposite day. So here we have a report from Chairman Bernanke saying that Medicaid among other entitlements are driving long-term deficit spending. You in your opening remarks mention how we, the Administration is concerned regarding the deficit, and yet when I look at all the literature given I see that here, according to CBO, Federal spending on Medicaid will increase by $674 billion over the next 10 years. I see from CMS actuaries that Federal—that State spending will go up by 190 billion and if you include the latest estimate from CBO that is probably more like 250 billion over the next 10 years. Now, clearly you are concerned about it.

I have a copy of your letter, which suggests to Governors a way that they can do it. For example, you suggest they could eliminate optional benefits like pharmacy coverage. And Massachusetts is doing that sort of thing because, as their budget chairman says, their current Medicaid growth is unsustainable. Mr. Engel—I'm sorry he has left, but I have a Deloitte Report which I will submit for the record that estimates that under PPACA 50 percent of New York's State budget may go to Medicaid by 2030. Now with all this said, first, it does seem like opposite day. It does seem as if there is concern for the deficit and yet we are driving the deficit with this bill. And secondly, regarding maintenance of effort, you mentioned your hands are kind of tied, if you will. Will you commit to working with Congress, with us, to help the Governors with this maintenance of effort so that they don't have to necessarily slash dental benefits in Massachusetts or something else in New York? I ask your thoughts.

Ms. SEBELIUS. Well, Congressman, I share your concerns about healthcare costs driving the deficit and I don't think there is any question that it is the number one cost driver. I would suggest that what we have to do—and I am convinced we have a new platform to work on this—is actually also look at the underlying cost drivers with which rather—whether you are talking about the public programs, Medicare or Medicaid, or the private sector trying to provide healthcare, we have a trajectory on healthcare costs that is simply unsustainable.

Mr. CASSIDY. Can I—just because I have limited time and I want your thoughts. Massachusetts, as the Governor said, is certainly the harbinger of how things are going to come. I see over the last 10 years their State budget going towards healthcare expenses has gone from 21 percent to 37 percent. That is why they are now slashing benefits. So it seems like, if this is going to control costs, when does it begin?

Ms. SEBELIUS. Well, I think that the Massachusetts program is a great example. And I think it is a great example of what is possible on the exchange side and with coverage which Congressman Weiner mentioned. But it also had a missing component. Governor Romney and certainly Governor Patrick would be the first to tell you that when Massachusetts designed their program they focused on access and not on cost containment and——

Mr. CASSIDY. Now if I can——

Ms. SEBELIUS [continuing]. They are revisiting the cost containment phase.

Mr. CASSIDY. I am with you on that and when I look at what they—I am—just know and I have limited time. When I look at what they are proposing, none of which has been proven to control costs, it is all theoretical but it has not actually been proven. I think the Governor at one point proposed provider fee—freezing provider fees and that was thrown out by a judge. So it really seems as if the cost control mechanisms which again is similarly in PPACA have not been established to control costs.

Ms. SEBELIUS. Well, I think the Affordable Care Act has as an underlying premise a huge number of underlying cost control, both delivery system changes but I think more importantly—and unfortunately the Congressional Budget Office hasn't scored this—but the effort to look at the drivers of chronic disease, which is where we spend about 75 cents of every heath dollar, obesity and smoking can have the most enormous effect on your children's health care.

Mr. CASSIDY. I wish I had 5 more minutes. Let me interrupt. Let me ask one more thing because I am out of time. You mentioned that the CLASS Act, you are kind of concerned about it. It is $75 billion scored by CBO towards the credit side of PPACA. On the other hand, you mentioned that it is unsustainable. It seems a little disingenuous for something which really long term is not really sustainable to then claim it as kind of a credit in terms of proving the costworthiness of a bill.

Ms. SEBELIUS. The Deficit Commission recommendations were that we either should look at repealing the CLASS Act or reforming it, and we have the flexibility administratively to do the latter. That is exactly what we intend to do, and I look forward to visiting with this committee, as I pledge to do, to tell you the outlines of what we think will be a sustainable program.

Mr. CASSIDY. And could I ask you the one question I asked at the beginning. Would you pledge to work with us on helping the States on a bipartisan basis for their maintenance of effort?

Ms. SEBELIUS. We are in the process of doing that right now. Yes.

Mr. PITTS. The gentleman's time has expired.

Chair recognizes gentleman from Kentucky, Mr. Guthrie, for 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you Madame Secretary. I think I may be the last one on the panel, so hopefully we are moving forward. One thing that Mr. Weiner brought up if you expand Medicaid to 100 to 133 percent you are going to bring on children and the parents but you also are going to bring on the disabled and the elderly in big proportions. And if the economy does grow as Governors are looking if you think we can just grow out of it the most expensive people who participate in Medicaid are the disabled and elderly which are more not as elastic to getting jobs if the economy moves forward. They are still going to be with us. So the fact that we can just grow out of this is not really necessary. I just want to make that point.

And when you made your opening remarks you listed a lot of the things that people have been listening that people like about the healthcare act: preexisting conditions for children, 26-year-olds you

can stay on, and you also said—and I think I will quote "businesses are getting relieved. They are also—business are getting relieved from rising healthcare costs." And I can tell you from businesses I know that because of the new benefits that are mandated premiums are rising as they have already started rising. So I just—the evidence that business costs are decreasing—I—we haven't seen that. Hopefully you have and I can share it with businesses and see what they need to do differently.

Ms. SEBELIUS. Well, short term, Congressman, as you know, small business owners are eligible for a tax credit which helps provide some relief to the costs of covering their employees. And what I hear from small business owners across the country is that is often their biggest bottom line cost and the way they lose their best employees to their larger competitors. So that provides some short term relief. Long term relief comes in 2014 with a new market where they will finally have the leverage buying power that their large competitors have.

Businesses on average, small business owners, spend about 25 percent more on exactly the same coverage as does someone with market power, and in 2014 those rates—and, again, CBO and other actuaries have said—those rates will come down fairly dramatically.

Mr. GUTHRIE. But medium-sized businesses are seeing—I know businesses with 400 employees and they have seen an increase because of the new mandated benefits. I mean that I moving forward already reflecting—because you can increase benefits. But if you are going to increase benefits you are also going to—there is a cost to that and it is reflected in the premiums businesses are paying.

Ms. SEBELIUS. Well again, the actuarial reports that I have seen indicate that there is a relatively insignificant impact at this point on the kinds of benefits going forward. And as you know we are trying to—the Waiver Program that has been mentioned a number of times which dealt with one feature of the bill, the Annual Limit, was designed to try and insulate businesses in the short term from the kind of rate shock that they may see. So we are in a balancing act getting between now and 2014.

Mr. GUTHRIE. So we need to be mindful—obviously businesses plan for their long term success, too. And I don't—you understand that. I know we need to work together. I had a couple of physicians. One that wanted about a minute. Can I give you a minute and him a minute? Yield a minute to the gentleman from Texas.

Mr. BURGESS. Thank you. Madame Secretary, again thank you for being here and you know where we are. Don't make yourself so scarce. Going back to 4101A and B for just a moment: the mandatory funding for the construction of the clinics, the discretionary funding for the staffing of the clinics. There was no request in the budget for the discretionary money for the funding of the clinics. So are we likely to be left with a situation where we are required to build them under mandatory funding but no one to staff them under discretionary funding? These are the school clinics under 4101A and B?

Ms. SEBELIUS. Congressman, all I can tell you is the budget does include in the Health Resources and Services Administration a request for increased funding with regard to community health cen-

ters for the workforce for new National Health Service Corps providers and new primary care providers.

Mr. BURGESS. It is specifically the school-based clinic.

Ms. SEBELIUS. But I—those are part of the——

Mr. BURGESS. Maybe you could get that answer back to me in writing.

Ms. SEBELIUS. Yes, that is fine.

Mr. BURGESS. I yield back to the gentleman from Kentucky.

Mr. GUTHRIE. I want to yield the remainder to the gentleman from Louisiana.

Mr. CASSIDY. Just one more question, Madame Secretary. I am sorry.

Ms. SEBELIUS. OK.

Mr. CASSIDY. To follow up on Congresswoman Schakowsky's—since it is my understanding that we are raising Medicare premiums to close that doughnut hole, what will the seniors do if they are able to keep their own money as opposed to closing the doughnut hole? And of course——

Ms. SEBELIUS. I am sorry. We are raising Medicare premiums?

Mr. CASSIDY. It is my understanding that Medicare Part D premiums are going up to close that doughnut hole. Is that not true?

Ms. SEBELIUS. No, sir, I don't think that is accurate.

Mr. CASSIDY. Well, then I will follow up with that at a later date.

Ms. SEBELIUS. OK.

Mr. CASSIDY. Thank you. I yield back.

Mr. BURGESS. Will you yield to me?

Mr. CASSIDY. Yes, I yield to the Texan from Texas.

Mr. BURGESS. We haven't yet talked about the sustainable growth rate formula and that was one of the big omissions from PPACA. All of the money taken out of Medicare and not a single dime for a down payment for buying us out of the SGR reductions. What are your plans for getting us out of the SGR?

Ms. SEBELIUS. Well, as you know, Congressman, the SGR dates back to 2002 and has been an issue that has not been effectively dealt with. This President since his first budget has recommended a long term fix. He has proposed in this year's budget not only working with Congress for a 10 year resolution, but also put more than two years of funding into the budget. So we would look forward to working with this committee to find a long term fix. I agree with you it is probably the single most threatening issue to Medicare beneficiaries on the horizon.

Mr. PITTS. The gentleman's time is expired. Chair recognizes the gentleman from New York, Mr. Towns for 5 minutes.

Mr. TOWNS. Thank you very much, Mr. Chairman. Secretary Sebelius, thank you so much for testifying before the committee—subcommittee. I know your time is valuable, so I will be brief with my questions.

First, I should note that I am pleased to see the direction that the Administration has taken on the budget requests. I am concerned that should the cuts proposed by H.R. 1 pass, HHS would not be able to deliver on key services and programs that benefit the public. Let me—an area that I am very concerned about is the community health centers. They provide an extremely valuable service in my district as I imagine they do for many members on both

sides of the aisle, even though some might not admit it. I understand that the proposed cuts in H.R. 1 would have a devastating impact on community health centers, possibly closing up to 127 health centers and cutting off 11 million patients over the next year. In contrast, how has the HHS budget request dealt with these very valuable centers?

Ms. SEBELIUS. Well, Congressman, I share your appreciation for the critical services that health centers provide in our most underserved areas. And between the investment of the Recovery Act, the President's budgets, and the Affordable Care Act, the goal is to really double the number of Americans who have access to those vital high quality, lower cost, preventive services. And the President has made a budget request for an increased support for community health centers including for providers who serve in that—in those centers, training 15,000 new providers over the course of the next five years and having those folks available. Absent that expanded footprint, we will have far more people accessing healthcare in the least expensive—I mean, the most expensive, least effective way through the doors of emergency rooms or just not getting the health care at all.

Mr. TOWNS. Let me say I was watching this hearing on TV earlier and I saw a member raising a booklet saying this is why you are in the minority—and I hope that you know you are not affected by that in any way because you know sometimes, you know it takes some people a little longer to figure out what is going on. And I think that we need to just move forward because I think that there is no question in my mind that this is going to save a lot of lives and eventually we are going to save a lot of money. There is no question about it.

So I am hoping that, you know you don't let this deter you in any way. You continue to move forward. Let that encourage you because let us face it, eventually they will get the message as well. So I want to thank you very, very much for the work that you are doing and we look forward to continuing to work with you.

I think the only thing I would hoped that we would be able to put together some more private and public partnerships maybe even around the community health centers to see in terms of what we might be able to do to sort of keep them open because they provide such a valuable service in many, many neighborhoods.

Ms. SEBELIUS. Well Congressman, every place I go I try to visit the community health center that is closest and I have seen some extraordinary providers across this country who not only are providing life saving medical care, but incredible family support. And I don't disagree that it is proven over and over again to be not only very high quality care but at a far lower cost than any variety of options. So I would look forward to looking for you to make sure that this incredibly important public support stays in place.

Mr. TOWNS. Thank you very much and on that I yield back.

Mr. PITTS. Chair thanks gentleman. The gentleman from Kentucky, Mr. Whitfield, is recognized for 5 minutes for questions.

Mr. WHITFIELD. Well, thank you, Mr. Chairman. And Secretary Sebelius, thank you for being with us today. One comment that I just wanted to make which probably doesn't have to be made but I am sure you have felt a lot of animosity, even a lot of frustration

over this whole healthcare bill as many in America has felt. And one of the reasons that people have felt that way is that they brought a 2,400 page bill to the House floor last year and we were not able to offer one amendment on the House floor.

And I don't think the American people appreciate bills of that magnitude having the impact on this country and the legislative body not being able to offer one amendment on the House floor. It is certainly not your fault. You were not the Speaker, but from that background and because of that process there is still very strong feelings about the issue.

But one of the questions I would like to just ask you, many members of Congress to be honest did not have much of an idea of what was even in the bill when we voted on it. And as Secretary of HHS I am assumed that in the process of developing the bill you must have at least been consulted. You were hopefully able to suggest ideas and have some input into the process.

So my first question would be did you have an opportunity to have input into the process?

Ms. SEBELIUS. Yes, Congressman, I did and as you know there were five committees, three in the House and two in the Senate. There were numerous hearings and yes——

Mr. WHITFIELD. No, I know that now. Just a minute——

Ms. SEBELIUS [continuing]. I did——

Mr. WHITFIELD. We, in fact, we adopted eight amendments in the Energy and Commerce Committee. All of them were stripped out before it went to the floor and Democrats and Republicans adopted those amendments. They all were stripped about and we were not offered—able to offer one amendment on the floor. But here is the question I have. We know that there is going to be about 20 million more people on the Medicaid program according to all of the numbers that we have seen by the year 2014 or whatever. And every Governor that I talk to both Democrat and Republican say that one of the reasons they are having financial difficulty in these States—not the only reason, but one is the fact of the cost of the Medicaid program. Now, the States are having great financial difficulty. The Federal Government goes without saying. We have a $14 trillion Federal debt. How is it concluded that the Federal Government would pick up 100 percent of the cost of those additional 20 million people on Medicaid?

Now I have heard some comment, well, the States are not going to be hit with this additional cost. Well, the reason they are not going to be hit with it is because the Federal Government is. So my question would be, how was it determined that the Federal Government should do that when we are in worse shape at the Federal level than some of the States are at the State level?

Ms. SEBELIUS. Well, Congressman, I think it was seen as a way to have a partnership going forward and, for the first time ever, have a benefit level that, regardless of where you lived in this country, you were eligible for health insurance so that uniformly now, across the country, at—families at 133 percent of poverty or less would qualify and for that additional population some States are well above that right now, some States are well below it. But for the additional population, at least for the first three years, it

was seen that the Federal Government should pick up the lion's share and then gradually the State would participate.

Mr. WHITFIELD. Well, I—I mean if I had been there I think I would have disagreed with that but nevertheless that is what it is. But the thing that really bothers me—when you talk to primary care physicians today they are already upset about the low reimbursement rates for Medicaid patients and I don't think I am exaggerating we have two doctors here and maybe some over there. Most of the primary care physicians I talk to say we are not going to take any more Medicaid patients. So if you put a 20 million more people on there, they are going to go right back to the emergency room.

Ms. SEBELIUS. Well, I—at least the doctors who I talk to across the country, and I do visit with a lot of them, are not happy with the Medicaid reimbursement rates. But the vast majority of the people we are talking about have no reimbursement rates, are not seeing a doctor, are using the healthcare system in a very inefficient way. I think one of the reasons that, again, the Affordable Care Act suggests that Medicaid doctors for at least the first several years will be paid at Medicare rates is a recognition that the Medicaid rates across the country are insufficiently low. And that is again part of the Affordable Care Act's structure.

Mr. PITTS. The gentleman's time is expired. We have one other member who is not a member of the subcommittee. He is a member of the Full Committee. He has waited patiently all hearing at our times past. Would you stay for 5 minutes?

Ms. SEBELIUS. Yes.

Mr. PITTS. Thank you, and the Chair recognizes the gentleman from Texas, Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman and I appreciate the courtesy. Let me waive on. This is my first term on the Energy and Commerce Committee. I haven't been on the Health Subcommittee and so I appreciate the chance to be here. Welcome Madame Secretary.

Ms. SEBELIUS. Thank you.

Mr. GREEN. And I just want to remind folks the Medicaid reimbursement rates are set by the States.

Ms. SEBELIUS. That is correct.

Mr. GREEN. And we had three Governors here yesterday or a couple days ago with our oversight and investigation and they wanted more flexibility and they have a lot of flexibility now in reimbursement rates. And there are some decisions that can be made because—and I think we are right. We understand that doctors Medicaid pays less than Medicare. Frankly, in my part of the country, TriCare pays less than Medicare. So you know, although in the Houston area where I am from we don't have a big base, so a lot of physicians won't take TriCare because it is so—but that is a State issue. We don't want—we definitely don't want the State—Federal Government to set Medicaid rates because we would have more Governors up here complaining.

But the other issue I want to ask is on the Healthcare Reform bill, the impact on the teaching health centers, our medical schools and that are associated, what is the impact that you are seeing on our teaching health centers because we are fortunate at least in

the Houston area to have three that serve our metropolitan area. And my goal is to encourage them to get out to our community based health centers and partner with them because that way I also want those residents to understand they can make a good living in a community based health center.

Ms. SEBELIUS. Well, recently I had the chance to visit again with the head of the Association of Academic Health Centers and he joined a group of providers talking about what he sees as an enormously important opportunity to begin to transform healthcare delivery with the Affordable Care Act. That the patient-centered, provider-centered opportunities with the kind of payment models that are a part of the Affordable Care Act, everything from primary medical home models which actually reimburse physicians for keeping their patients healthy in the first place and you don't have to wait until they go to the hospital to get paid, to bundling care, to using the most innovative strategies they see as a wonderful opportunity. And, as you say, in many areas already there is a lot of discussion with academic health centers and community health centers about becoming Accountable Care Organizations and combining those strategies to deliver better care to more people.

Mr. GREEN. OK. I know that H.R. 1 cut or proposed to cut 1.3 billion from the health centers program and I understand the Health Centers Services Resource Administration has announced its intention to award new access points, new health centers and new sites of existing centers. And as you know this funding opportunity to facilitate health centers expansion made possible by provisions in the Health Reform Law and the President's request. And frankly I worked with the Administration under President Bush many times expanding health centers funding. Can you tell us how many applications for new health centers HRSA has received and how many awards HRSA intends to fund, and how many of the awards would HRSA make if H.R. 1 if was enacted and 1.3 billion were cut? I know that may not be possible now.

Ms. SEBELIUS. Congressman, I would love to get you those specifics——

Mr. GREEN. OK.

Ms. SEBELIUS [continuing]. In writing, but suffice it to say that the loss of the investment in anticipated would severely curtail this program.

Mr. GREEN. You have better information than I do, but we were understood that there were about 800 applications for 350 possible awards. But again, you have the exact numbers. That is what we have heard. So Mr. Chairman, I know I have a little bit left. It is well documented health centers provide high cost effective and high quality patient directed care and reduces overall costs in the healthcare system. Can you describe the overarching impact of the healthcare system and the continued healthcare expansion outlined in President's fiscal year 2012 budget request?

Ms. SEBELIUS. Well I think, Congressman, the anticipation is that we would be able to gradually move from serving 20 million Americans to 40 million Americans. And as you know the Health Services Resource Administration maps pretty carefully where is the underserved need, where are the access points that need to be filled. Some are in very rural areas, some are in very urban areas

and that expansion has provided enormously important care to families across this country.

Mr. GREEN. Thank you and I appreciate it. And I know I am almost out of time, but in the Houston area we got—we started on community health centers much later than most parts of the country so we are considered I think an under-underserved area. But——

Ms. SEBELIUS. You putting in a pitch?

Mr. GREEN [continuing]. But also the community health centers are not refusing Medicaid patients.

Ms. SEBELIUS. That is correct.

Mr. GREEN. So doctors cannot afford in their practice to take them that is why we need expansion of community health centers.

Ms. SEBELIUS. Some are uninsured, some are Medicaid, but a number of people are fully insured and choose a community health center as their health home.

Mr. PITTS. Gentleman's time——

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS [continuing]. Is expired. In conclusion, I would like to thank Secretary Sebelius and the members for participating in today's hearing. I remind members that they have 10 business days to submit questions for the record and I ask Secretary Sebelius to respond promptly to the questions.

Ms. SEBELIUS. Thank you, Mr. Chairman.

Mr. PITTS. Members should submit their questions by the close of business on March 17.

Mr. BURGESS. Mr. Chairman, would you yield for a moment for a unanimous consent request?

Mr. PITTS. Yes.

Mr. BURGESS. I have a unanimous consent to add the letter that I wrote to Secretary Sebelius on February 10 to the record.

Mr. PITTS. Without objection it will be entered into the record.

Mr. BURGESS. Thank you.

[The information follows:]

MICHAEL C. BURGESS, M.D.
26TH DISTRICT, TEXAS

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February 11, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

I write to inquire of the Department of Health and Human Services your response to and specifically subsequent implementation decisions made by the Department in the wake of Judge Vinson's ruling in *The State of Florida v. United States Department of Health and Human Services*. As you are well aware, the plaintiff sought declaratory judgment that the Patient Protection and Affordable Care Act is unconstitutional as well as an injunction against its enforcement.

In his opinion, Judge Vinson relied on precedent in *Committee on Judiciary of U.S. House of Representatives v. Miers* to determine that when a court issues a declaratory judgment against federal officials, the "declaratory judgment is the functional equivalent of an injunction." He quoted a previous United States Court of Appeals decision which further addressed his point, "that officials of the Executive Branch will adhere to the law as declared by the court. As a result, the declaratory judgment is the functional equivalent of an injunction . . . There is no reason to conclude that this presumption should not apply here. Thus, the award of declaratory relief is adequate and separate injunctive relief is not necessary."

I would like to request information on how, in light of the declaratory relief issued by Judge Vinson, the Department plans to proceed in its implementation of the Patient Protection and Affordable Care Act.

Thank you for your time and consideration on this issue and I look forward to your response. Should you have any questions, please contact me in my Washington office at (202)225-7772.

Sincerely,

Michael C. Burgess, M.D.
Member of Congress

Mr. PITTS. If there is nothing further before the committee, this subcommittee hearing is adjourned.

[Whereupon, at 12:11 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
Subcommittee on Health
"FY 2012 HHS Budget and the Implementation of Public Laws 111-148 and 111-152"
March 3, 2011

Thank you, Mr. Chairman.

I first want to take a moment and welcome Secretary Sebelius to the Committee today. Secretary you have the tremendous task of implementing the historic Affordable Care Act and the FDA Food Safety Modernization Act. Both of these laws are critical to the safety and well-being of the American public and I comment you for your dedication to their implementation.

President Obama has set forth a challenge for our federal government to out-educate, out-build and out-innovate the rest of the world, while also balancing the need to lower our debt for the generations to follow. I know that this is a painstaking task, and with a task of this nature, difficult decisions and cuts are inevitable. As Members of Congress we are faced with this task during the appropriations process.

In previous Congresses Members took the time during budget discussions to evaluate cuts to programs and determine what impacts they would have before moving forward. As seen in H.R. 1 the new Majority has not taken this approach. Instead they have taken a sledgehammer to our nation's budget with an 'act-now, think-later' mentality. This may be acceptable when dealing with one's own bank account, but it is not acceptable when dealing with the nation's.

The cuts of H.R. 1 are long, massive, and reckless:

- $624 million from the Social Security Administration operations,
- $1.1 billion from Head Start,
- $5.7 billion from the Pell Grant program,
- $241 million from FDA,
- $1.3 billion from the Health Centers program, among others.

This sledgehammer approach does not take into consideration the needs of our children, our elderly, our sick, or our families, and I was pleased to see the Administration take a more measured approach.

As we move towards deliberations on the FY12 budget I hope to work with you Secretary to ensure that the Affordable Care Act and the FDA Food Safety Modernization Act impeded in any way by funding cuts. For the health of the American people, these laws must be implemented fully and swiftly.

Thank you, and I look forward to hearing your testimony.

Statement for the Record

Rep. Towns

Mr. Chairman, and Ranking Member Pallone, thank you so much for convening today's hearing on the President's Proposed FY12 Budget for the Department of Health and Human Services, and the Implementation of health reform. Secretary Sebelius, thank you so much for testifying before our subcommittee today.

First, I should note that I am pleased to see the direction that the Administration has taken on the budget request. The budget request takes our nation's mounting deficit very seriously, and is in line with the President's promise to free discretionary spending for the next five years. In fact, the HHS budget, if approved, would provide a slight decrease to the total budget authority for discretionary programs. This is partially because the majority of the HHS budget provides funding for Medicare, Medicaid, the Children's Health Insurance Program, and Indian Health Services beneficiaries and enrollees – mostly mandatory spending programs. For CMS, only 0.6% of the proposed budget would be used for program administration, claims processing, quality assurance activities, and efforts to control waste, fraud, and abuse. The remaining 99.4% provides for the health needs of seniors, persons with disabilities, children, and other beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program.

In addition, the budget makes sound investments in our nation's health care workforce, community health centers, and in our nation's scientists. These investments are crucial to ensure the continuing health and prosperity of our country.

However, I am very concerned that should the cuts proposed by H.R. 1 pass, HHS would not be able to deliver on key services and programs that benefit the public. This would have a serious impact on access to healthcare services for Medicare & Medicaid beneficiaries. Namely, nearly half a million new Medicare beneficiaries would not be able to obtain care because there would be a certain enrollment backlog for this year. In addition, the proposed cuts would jeopardize payments of claims for services including inpatient hospital stays, physician visits, durable medical equipment, and other vital medical services. If the program does not pay in a timely manner, this would result in physicians dropping patients on Medicare. CMS is also responsible for ensuring that payments are accurate and that the programs' safeguards against fraud are maintained. H.R. 1 would impair CMS' ability to fight fraud in these programs, which would divert the programs funds away from those who truly need it.

Community Health Centers would also seriously be threatened. Proposed cuts would result in the closure of 127 health centers, cutting off 11 million patients over the next year, and forcing layoffs of thousands of employees – in the middle of one of our highest unemployment periods in recent history.

Rather than propose cuts that would harm our nation's health and prosperity, we should be working together to ensure that investments are made in our children, our seniors, our scientific research, and in programs that are proven to ensure long-term returns.

Thank you, Mr. Chairman. I yield the balance of my time.

Deloitte.

Issue Brief:

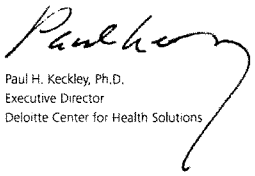
Medicaid Long-term Care: *The ticking time bomb*

Foreword

As the dust settles from passage of the 2010 Patient Protection and Affordable Care Act (PPACA), most state legislatures are left to ponder how they will ultimately fare, given growing fiscal constraints, increased enrollment in Medicaid and the Children's Health Insurance Program (CHIP), and a political season where government spending is likely to be a prominent issue. Appropriately, state leaders must look to promising areas where opportunities for cost savings also improve results. Among these is long-term care (LTC) for the Medicaid population.

Left unattended, states' obligation to their LTC Medicaid enrollees has the potential to debilitate government effectiveness. The health care reform bill provides little near-term relief: States must innovate with a sense of urgency to address this burning platform.

Medicaid LTC programs offer significant opportunity for state officials to demonstrate leadership; however, it requires urgent, thoughtful attention and deliberate action.



Paul H. Keckley, Ph.D.
Executive Director
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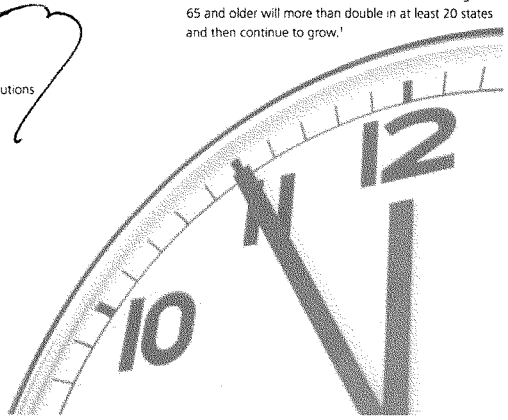
Executive Summary

There currently is no coordinated, comprehensive system of the provision and financing of LTC services in the United States. For the disabled and elderly who lack personal financial resources, navigating the complexities and regulations associated with LTC decisions can be extremely challenging. No less daunting is the task facing policy makers, whose decisions on behalf of these vulnerable populations directly and dramatically affect both state and federal budgets.

By design, state-administered Medicaid has become the nation's primary funding source for LTC for those in need. Because of this, the pressure on states to control costs while making effective decisions regarding the provision of community- versus institutional-based LTC services presents an opportunity to transform LTC as a whole. This transformation assumes a sense of urgency as state and local governments face new and growing fiscal challenges generated, in part, by the needs of an aging Baby Boom generation. Prior to 1995, elderly residents exceeded 15 percent of the population in only five states; by 2025, the elderly will exceed 15 percent in every state except California and Alaska. The number of Americans aged 65 and older will more than double in at least 20 states and then continue to grow.[1]



Produced by the Deloitte Center for Health Solutions

Current health care reform efforts have been focused on controlling costs and increasing health care access for the uninsured, poor, elderly and disabled. The 2010 PPACA was signed into law in March; however, the full effect of this landmark legislation may not be apparent for several years. As evidenced by the public response to health care reform activities, it is clear that the outcomes of the PPACA legislation will be of great interest to Baby Boomers, who will increasingly rely on public programs for care.

Glossary of Key Terms

Medicaid: Medicaid is a state and federal government program that pays for certain health services and nursing home care for people with low incomes and limited assets. In most states, Medicaid also pays for some LTC services at home and in the community. Eligibility requirements and services covered vary from state to state. Most often, eligibility is based on income and personal resources.

Long-term Care (LTC): LTC includes medical and non-medical services for people who have a chronic illness or disability. LTC helps meet health or personal needs. Most LTC services assist people with daily living like dressing, bathing, and using the bathroom. LTC can be provided at home, in the community in assisted living facilities or in nursing homes. LTC may be needed at any age.

In-home/Community Care: In-home/Community Care programs provide personal activity assistance to seniors and people with disabilities. Example programs include Meals on Wheels, transportation services, adult day care and chore services.

Institutional Care: Institutional care facilities provide care to individuals who cannot be cared for in the community or at home. Examples include nursing homes and some assisted living facilities.

The convergence of an aging population and health care reform's mandate for increased access to care will have far-reaching consequences for Medicaid. Not only will it force Medicaid to examine existing benefit programs for the elderly and the poor, it will also push Medicaid to rethink how it can address the full range of elderly needs with the resources it possesses and can mobilize. A key beneficiary of those resources will be people needing LTC.

This paper examines the Medicaid expenditures for LTC, in both institutional and community-based settings. If the current trend continues as demonstrated in this paper's base model, more than 35 percent of a state's budget will be needed for Medicaid by 2030, of which half will be for LTC services. Research indicates that nursing facility expenditures are not driving this cost escalation, so a push to manage LTC costs by eliminating less-costly home/community care programs could boomerang, with the result that beneficiaries end up requiring more costly institutional care.

The paper also examines how health care reform's mandate for increased access will worsen Medicaid's expenditure trend. The Senate bill estimated that Medicaid coverage would be expanded to include an additional 14 million individuals. At a time when unemployment rates remain high, state tax revenues have decreased and state budget deficits have increased, states are being asked to do more with less in regard to health care resources. While the bill states that new Medicaid enrollees will be subsidized through 100 percent federal funds from 2014 to 2016,[2] state budget deficits are projected to be more than $350 billion between 2010 and 2011, a dangerous fiscal scenario for which there is no short-term solution. This paper presents ideas for consideration for states to transform their Medicaid LTC programs to help address budget constraints – and to find the way to do more with less.

1 U.S. Census Bureau

2 Except for Nebraska, which will receive a permanent federal subsidy to cover the costs of increased Medicaid eligibility under the bill.

Overview

Medicaid is the primary payor for LTC services and support to the elderly and disabled in the U.S.[3] and, by default, has become the primary support for U.S. LTC.[4] Medicaid currently finances nearly 34 percent of all home health care and 43 percent of the nation's nursing home spending. Medicaid covers a wide range of LTC services, including a broad spectrum of critical support for the poor in both community and institutional settings. The total LTC Medicaid expenditures for FY 2008 were $106.4 billion – 32.1 percent of Medicaid's total spending of $331.8 billion. That same year, institutional LTC spending rose 2.9 percent to $61 billion and community-based LTC spending rose 4.9 percent to $45.4 billion. The distribution of LTC resources between institutional care and home/community-based care was 57 percent and 43 percent respectively.[5]

The balance between institutional LTC and community-based LTC services is important for several reasons. First, there is no comprehensive, well-coordinated system of LTC in the U.S. Second, an informal LTC system supported by unpaid family members and volunteer services is being strained by cultural, demographic and economic pressures. The relationship between institutional care and community care is not a simple one. For example, in situations where individuals have personal or family resources to support LTC, the high expenses of institutional care may result in impoverishment, leading to their eligibility for Medicaid and a resulting increase in Medicaid nursing home care expenditures.[6] Recent research has shown that individuals may be cared for in community settings without sacrificing quality and, in fact, with an increase in beneficiary satisfaction. However, in the current economic climate, more states are cutting in-home/community services to address their Medicaid LTC fiscal challenges. Unfortunately, these cuts will further aggravate state Medicaid performance since in-home/community programs are less expensive to provide and often reduce the need for institutional care.[7]

This paper highlights the potential state budget effects of the impending LTC services demand brought about by increasing Medicaid enrollments. It also presents scenarios that forecast two likely outcomes: The effect of the aging population's demographic bulge on Medicaid enrollment, and the potential increase in Medicaid eligibility due to legislative mandates associated with health care reform. The combination of these two potential outcomes could be a catastrophic fiscal "left hook" that state and federal policy makers ignore at their peril. To provide context for those states contemplating the policy implications arising from these outcomes, the paper provides a selection of innovative programs (both recent and current) that may be useful to policy makers as they consider ways in which to restructure or transform LTC services for their disabled and elderly Medicaid beneficiaries.

National Enrollment Trends in Medicaid LTC

The recession, increased numbers of unemployed who have lost employer-sponsored health care coverage, and the aging baby boomer demographic are some of the trends expected to affect health care spending – including Medicaid enrollment – in the next decade.[8]

Medicaid LTC spending, including community- and home-based services (HCBS), is expected to increase over the next decade. Projected combined federal and state Medicaid expenditures for 2009 represent a 9.9 percent increase over the prior year, for a total of $378.3 billion. This is the most rapid spending growth (10.7 percent) since 2002. The primary cause of this increase is postulated to be the rising unemployment rate during 2009, which resulted in a 6.5 percent increase in Medicaid enrollment.[9] Projections for 2010 Medicaid include 5.6 percent enrollment growth and 8.9 percent cost growth, again attributed to unemployment rates. If the economy continues to improve and the unemployment rate decreases, Medicaid is projected to grow an average of 7.5 percent per year, due primarily to increasing age-related beneficiary enrollment and LTC services for the disabled and elderly populations.[10]

3 Catlin A, Cowan C, et al. (2008). "National Health Spending In 2006: A Year Of Change For Prescription Drugs," *Health Affairs*, 27(1): 14-29, http://content.healthaffairs.org/cgi/content/abstract/27/1/14. Accessed March 6, 2010.

4 National Governors Association. Policy Position HHS-28. Long-term Care. 28.1 Preamble, Accessed February 25, 2009, http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a27811050101oa0/?vgnextoid=47a0d3add6da2010VgnVCM1000001a01010aRCRD&vgnextchannel=4b18f074f0d9ff00VgnVCM1000001a01010aRCRD. Accessed February 23, 2010.

5 Burwell B, Sredl K and Eiken D. *Medicaid Long-Term Care Expenditures in FY 2008*, Research Paper, Thomson Reuters, December 1, 2009. pp.1-2. http://www.hcbs.org/files/165/8249/2008LTCExpenditures_final.pdf. Accessed March 6, 2010.

6 2008 Actuarial Report on the Financial Outlook for Medicaid; Office of the Actuary Center for Medicare & Medicaid Services, http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf. Accessed March 6, 2010.

7 Catlin A, Cowan C, et al. (2008). "National Health Spending In 2006: A Year Of Change For Prescription Drugs," *Health Affairs*, 27(1): 14-29, http://content.healthaffairs.org/cgi/content/abstract/27/1/14. Accessed March 6, 2010.

8 Truffer CJ, Keehan S, et al. "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs*, 29(3): 522-529.

9 Ibid, p. 527

10 Ibid, p. 527

The use of HCBS is expected to increase substantially more than institutional care; this shift toward non-institutional settings for LTC is attributed to beneficiaries' perceived preference for non-institutional settings, and the tendency for community settings to be less costly than institutional sites.[11] Despite this increase, in 2007, only 31 percent of Medicaid LTC expenditures were attributed to community care.[12]

Medicaid spending on blind or disabled beneficiaries is expected to grow the most rapidly, as they receive the largest amount of HCBS LTC. The blind and disabled increasingly have moved from institutional settings to HCBS as the availability of these services has expanded.

To more closely examine the financial implications of these trends, Deloitte modeled four scenarios as examples of potential impact on Medicaid costs:

- Scenario 1: Base Case Scenario – Trends without intervention,
- Scenario 2: Best Case Scenario – Five percent expenditure savings without enrollment increases,
- Scenario 3: Worst Case Scenario – 40 percent enrollment increase without expenditure decreases and
- Scenario 4: Most Likely Scenario – 20 percent enrollment increase.

Each scenario is presented for both Medicaid as a whole and Medicaid LTC services in ten states, representing multiple regions and the nation's most populous states. See Appendix for more information on the different scenarios and assumptions.

Who needs Medicaid LTC services?

According to a July 2006 report from the Kaiser Commission on Medicaid and the Uninsured, nearly 10 million Americans need LTC services. The majority of beneficiaries who receive LTC services are age 65 and above; 37 percent are under 65.

LTC includes a range of services that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include assistance with things like eating, dressing and toileting. IADLs include assistance with things that are not necessary for fundamental living but enable an individual to live independently in a community. These include doing light housework, preparing meals, taking medicine and grocery shopping.

For some people, LTC services are lifetime needs. Children born with severe physical impairments, developmental disabilities or a degenerative disease often need care throughout their lives. Teenagers and adults who incur traumatic brain injuries may need care for decades. The elderly often need some LTC services due to decreasing mobility and cognitive functioning that accompany aging. Those who are disabled by a serious illness often require more extensive services.

11 Ibid

12 National Conference of State Legislatures. http://www.ncsl.org/Default.aspx?TabID=1606tabs=832,98,333#333. Accessed March 6, 2010.

Emerging Trends for State Medicaid: A closer look across the most populous states

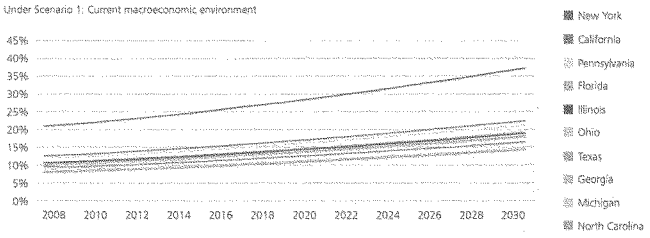
The 2008 Medicaid Report from the Centers for Medicare and Medicaid Services (CMS) projects that future LTC spending will increase at an average rate of 8.6 percent per year. CMS' projection is based on expected continuing increases in the use and costs of LTC, as well as projected increases in enrollment – especially for aged and disabled beneficiaries.

As Deloitte's model indicates (Figure 1), if the current trend continues, Medicaid budgets as a percentage of state operating budgets will almost double by 2030 – some reaching levels close to 40 percent. In certain states, expenditures for LTC account for about half of this trend (Figure 2).

CMS further expects HCBS to grow substantially more than institutional care, at an average annual rate of 11.9 percent and 5.5 percent, respectively. CMS attributes this difference primarily to the continuing trend of beneficiaries using non-institutional settings for a greater share of LTC services. Non-institutional care tends to be less expensive than institutional care, and beneficiaries are generally believed to prefer receiving care in their homes or communities rather than in nursing homes or other institutional settings.[13]

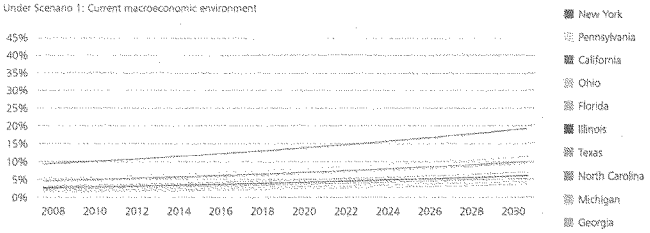
Scenario 1: Base Case Scenario – Current state of how Medicaid expenditures are trending without intervention

Figure 1: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS' projections for future growth in expenditures

Figure 2: LTC portion of states' operating budgets



Source: Deloitte LLP's model using CMS' projections for future growth in expenditures

13 Ibid

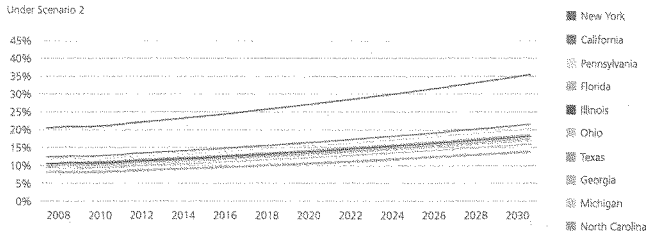
The Need for Transformation

One of the focuses of health care reform is increasing access to health care while constraining cost escalation. Deloitte has modeled various scenarios based on CMS' projections for future costs to provide examples of the impact of such reform on eligibility and resulting expenditure trends for LTC. The second scenario, presented here, assumes no increase in states' LTC eligibility (current macroeconomic trends continue) but models modest attempts at managing the current cost trend with a five percent savings to future Medicaid LTC expenditures.

As is evident in both Figure 3 and Figure 4, five percent savings will not significantly bend the cost curve. States will need transformational change to temper this cost trend. By 2030, LTC costs will still nearly double their percentage of the operating budget. Enterprise cost restructuring and fundamental program redesign will be needed to improve the efficiency and effectiveness of LTC cost performance.

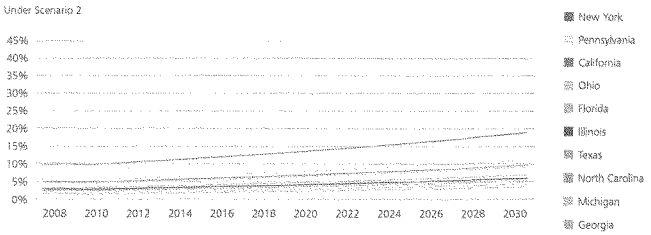
Scenario 2: Best Case Scenario – Five percent savings in future Medicaid LTC expenditures without enrollment increases

Figure 3: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Figure 4: LTC portion of states' operating budgets



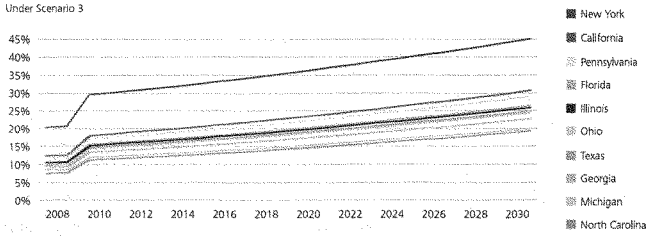
Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

In contrast, Scenario 3 (Figure 5 and Figure 6) assumes an aggressive 40 percent increase in Medicaid enrollment due to legislative mandates associated with the 2010 health care reform legislation.

In this scenario, the percentage of states' operating budgets allocated to LTC increases nearly three-fold – from 2008's 10 percent to almost 25 percent in 2030. In this worst-case scenario, Medicaid is projected to be close to 50 percent of the operating budget by 2030 for at least one state. Obviously, this is not sustainable.

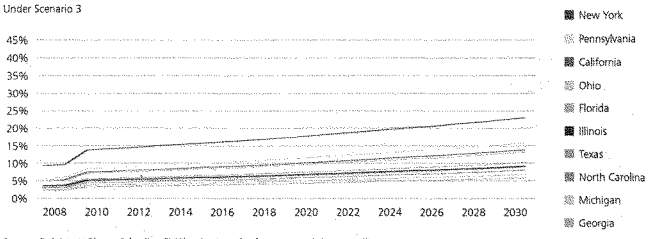
Scenario 3: Worst Case Scenario – 40 percent increase in Medicaid enrollment without cost savings

Figure 5: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS projections for future growth in expenditures

Figure 6: LTC portion of states' operating budgets



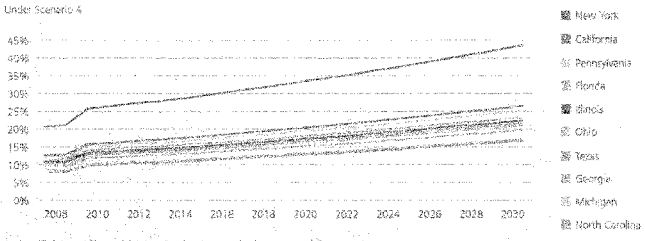
Source: Deloitte LLP's model using CMS projections for future growth in expenditures

Scenario 4 (Figure 7 and Figure 8), a more likely scenario, depicts a more conservative 20 percent increase in states' Medicaid enrollment due to legislative mandates associated with health care reform.

In this more likely scenario of health care reform's expansion of Medicaid eligibility, Medicaid will average nearly 25 percent of states' operating budget in 2030. LTC expenditures are modeled to average 10 percent of the states' operating budget, almost the same amount the total Medicaid budget equals today. As previously demonstrated, even a five percent savings on future Medicaid LTC expenditures would not significantly bend the cost curve.

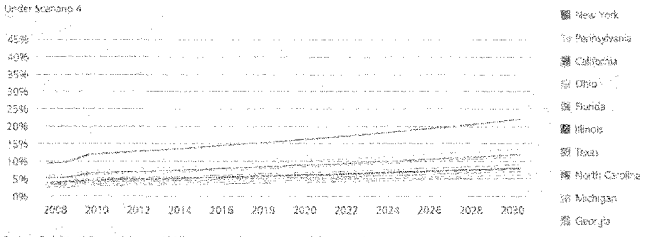
Scenario 4: More Likely Scenario – 20 percent increase in Medicaid enrollment

Figure 7: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS' projections for future growth in expenditures

Figure 8: LTC portion of states' operating budgets



Source: Deloitte LLP's model using CMS' projections for future growth in expenditures

Trend Summary

Across all scenarios, the results are the same. The portion of states' operating budget for Medicaid expenditures is increasing. In addition, the portion of the budget allocated to support LTC is increasing, and expenditures on nursing facilities are not the only driver. Despite pressures on states to reduce HCBS, the downstream consequences of doing so could be increased costs in institutional LTC, as beneficiaries could become more costly institutional patients. Instead, states should consider implementing aggressive/transformative actions to improve Medicaid LTC programs or continue to face the prospect of budget deficiencies.

Among actions needed to impact this escalating cost trend are enterprise cost restructuring and fundamental program redesign to improve the efficiency and effectiveness of LTC management. Important first steps are to understand the primary drivers of LTC and to analyze states' non-public data to identify what is occurring in LTC populations and to develop state-specific mitigating action plans.

Selected Factors Affecting LTC

LTC and medical expenditures are influenced by a number of factors. These factors, such as chronic disease incidence and innovative service delivery models, provide a context for considering implications of policy issues in this area.

Chronic Disease Incidence

Sixty percent of the U.S. population suffers from at least one chronic disease and the prevalence is higher among older adults; for example, for individuals over 80 years, at least 80 percent have two or more chronic diseases.[14] The most prevalent and/or high-cost chronic conditions are hypertension, diabetes, cancer (excluding skin), chronic obstructive pulmonary disease (COPD), acute myocardial infarction (AMI), coronary heart disease (CHD) and stroke. Excluding hypertension, the remaining conditions account for more than two-thirds of deaths in the U.S.[15]

Chronic Conditions Driving Medicare Spending

An April 2010 study reports marked changes over the past 20 years in the nature and location of treatment for U.S. Medicare beneficiaries.

1987: Intensive inpatient hospital services for heart disease accounted for the majority of growth in spending.

2006: Outpatient and prescription drug treatment for chronic care conditions—hypertension, diabetes, arthritis and kidney disease—accounted for the majority of the growth in spending.

- More than half of beneficiaries are treated for five or more chronic conditions.
- On average, a beneficiary is seen by two primary care physicians and five specialists in four practices.
- Due to deficiencies in the coordination of chronic care, beneficiaries receive only 56 percent of clinically recommended care.

The majority of both Medicare and Medicaid spending is associated with the treatment of chronic disease; when individuals are eligible for both Medicare and Medicaid services (8.8 million individuals), 98 percent of total expenditures are for chronic disease care. Approximately 39 million individuals with chronic care conditions also require LTC services, which include support for activities of daily living. Such individuals often have multiple care providers and multiple treatment and medication plans, with no primary source of coordination. This lack of continuity of care and coordination may lead to otherwise preventable emergency department visits, hospitalizations and nursing home admissions.[16, 17]

14 AARP and National Conference of State Legislatures. *Long-Term Care Reform Leadership Project Issue Brief No. 2.* June 2009, http://www.ncsl.org/documents/health/carecoord.pdf. Accessed March 6, 2010.

15 Joyce GF, Keeler EB, et al. (2005). "The Lifetime Burden Of Chronic Disease Among The Elderly," *Health Affairs*, hlthaff.w5.r18

16 AARP and National Conference of State Legislatures. Long-Term Care Reform Leadership Project Issue Brief No. 2. June 2009, http://www.ncsl.org/documents/health/carecoord.pdf. Accessed March 6, 2010

17 Thorpe KE, Ogden LL, et al. "Chronic Conditions Account For Rise In Medicare Spending From 1987 To 2006," *Health Affairs*, hlthaff.2009.0474.

In recent years, the rise in chronic disease has driven Medicaid to develop chronic disease management programs; however, such programs exist as demonstration projects on a state-by-state basis. Evaluating such programs and determining their relative effectiveness – both on expenditures and quality of care – have yet to be determined. However, a 2005 study of chronic disease showed that "although chronic conditions increase annual health care costs, cumulative spending for individuals from age 65 to death was only modestly higher for the chronically ill."[18] Such findings caution that although prevention, coordination and delaying therapies are valuable to pursue, the effect on health care expenditures may not show equivalent improvement.

Some Current Initiatives

The U.S. LTC system is fragmented and complex, and historically has been focused on the provision of institutional care. If private or family-supplied funding is not available to the elderly or disabled who require LTC, state Medicaid funds are required to support those needs. Every state has its own specific eligibility criteria for Medicaid and a complex set of other agency programs. Many public and private partnerships are developing to improve the quality of LTC, control spending and allow for community-focused, personalized, LTC systems.

The National Conference of State Legislatures is focusing on improving LTC in several key areas:

- Making LTC services more person-centered and community-focused,
- Coordinating health and LTC systems through Medicare and Medicaid,
- Developing a high-quality workforce and
- Exploring new public and private financing approaches.[19]

This section describes several LTC initiatives and program innovations.

Pilots and Demonstrations: Person-centered care

CMS is compiling a compendium of "Promising Practices in Home- and Community-Based Services" as a resource for states that are developing programs to promote person-centered and community-focused LTC. These summary reports generally focus on specific components of home and community services that may be included in a comprehensive program. The purpose of the Promising Practice reports is to stimulate innovation in community-based LTC.[20]

In a partnership model with states, consumers, providers and advocacy groups, CMS is working to establish programs that give individuals with disabilities and chronic conditions some choices, control and access to quality health care services that promote independence.

Independence Plus is a report that chronicles the experience of several states that tried innovations in programs designed to promote person-centered planning and services. These programs are defined as "state Medicaid programs that present individuals with options to control and direct Medicaid funds identified in an individual budget." There are eleven approved Independence Plus programs in ten states: New Hampshire, South Carolina, Louisiana, North Carolina, Florida, Maryland, California, Delaware, New Jersey and Connecticut.

Characteristics of LTC Community Service Programs: Partnerships with CMS and States, Consumers, Providers, Advocacy Groups

- Person-driven: Enables the elderly and individuals with disabilities to choose long-term care services they receive and community supports
- Inclusive: Provides supports for individuals to live with access to quality health and community services
- Effective and accountable: Promotes shared accountability between public and private partners, including planning for LTC needs with greater knowledge of private funding sources
- Sustainable and efficient: Coordinates and manages packages of LTC services
- Coordinated and transparent: Coordinates multiple funding sources for seamless support, using health information technology to provide transparency to all stakeholders
- Culturally competent: Accommodates individuals' cultural and linguistic needs in the provision of LTC services

18 Joyce GF, Keeler, EB, et al. (2005). *"The Lifetime Burden Of Chronic Disease Among The Elderly." Health Affairs*, hlthaff.w5.r18. (w5.r27.).

19 National Conference of State Legislatures: http://www.ncsl.org/Default.aspx?TabID=160&tabs=832,98,333#333. Accessed March 6, 2010.

20 See http://www.cms.hhs.gov/PromisingPractices. Accessed March 6, 2010.

21 See http://www.cms.hhs.gov/IndependencePlus. Accessed March 5, 2010.

Budgetary Adjustments

In the *Guide to LTC for State Policy Makers,*[22] rebalancing refers to the shifting of resources from institutional LTC to HCBS. New funding mechanisms and some federal "flexibility" have created the potential for consumers to remain in their communities for LTC. Several examples excerpted from the *Guide* include:

- Olmstead Supreme Court decision of 1999 – Increased state responsibility for providing a range of community options.
- Real Choice Systems Change Grants – $240 million provided since 2001 for state grants to set up such programs as person-centered care, Independence Plus initiatives, Nursing Home Transitions and Money Follows the Person.
- Deficit Reduction Act of 2005 – Allowed states to offer HCBS as a Medicaid State Plan optional benefit for qualified enrollees.
- Money Follows the Person – Individuals residing in nursing homes have the option to move to a community location. Public funds are transferred from the nursing home to community care.
- Nursing Home Transitions – Funds are authorized by state legislatures to assist in transitions to the community, including support for living arrangements such as security deposits, utilities and furniture.

Several states have used a combination of these initiatives to begin to balance their LTC services. Of particular note are initiatives in New Jersey, Minnesota, Iowa, Ohio, Vermont, Washington, New Mexico and Massachusetts.[23]

Innovation in Service Delivery Models[24]

State and local agencies that provide assistance for individuals who require LTC services have historically not been visible to those who most need help. Both funding and fragmentation issues have plagued the relationship between resource groups and the potential recipients of their services. Some examples of initiatives to address these issues are:

- Aging and Disability Resource Centers (ADRCs) – Funded by federal grants, the goal of these centers is to provide one-stop access for all LTC publically funded services, and to provide prompt Medicaid eligibility determination. Since 2003, CMS and the U.S. Administration on Aging have provided funds to establish ADRCs in 43 states. Demonstration pilots are established at over 100 sites.
- Consumer-directed Care – Through its *Cash and Counseling* program, the Robert Wood Johnson Foundation has provided states with demonstration funds for consumer-directed LTC. The program allows consumers receiving care in their homes to control their LTC funds in hiring and service decisions. Similarly, other states have developed Personal Care Option programs under the Medicaid waiver.

22 National Conference of State Legislatures, http://www.ncsl.org/Portals/1/documents/health/rebalancingltc.pdf. Accessed March 5, 2010.

23 AARP and National Conference of State Legislatures. *Shifting the Balance: State Long-Term Care Reform Initiatives.* Issue Brief No. 1 of 5, February 2009, pp.1-10. http //www.ncsl.org/?tabid=17679. Accessed February 23, 2010.

24 National Conference of State Legislatures, http://www.ncsl.org/Portals/1/documents/health/rebalancingltc.pdf. Accessed March 5, 2010.

Funding Innovations[25]

Many states have taken advantage of various financial opportunities to reform certain aspects of LTC services. Examples include:

- LTC Partnership Program – Consumers who purchase LTC insurance through a partnership policy have access to Medicaid coverage once the insurance benefits are exhausted, without using personal assets to qualify for coverage. The goal is to reduce the exhaustion of personal resources for nursing home care, which may delay the need for Medicaid support.
- Global Budgeting – LTC programs and budgets are consolidated into one state agency or institution and HCBS monies are pooled into one budget with a cap on total spending.
- Own Your Future – Through this grant funded by the Department of Health and Human Services (HHS), 15 states have developed public awareness campaigns for LTC planning. A 2008 initiative is the National Clearinghouse for Long-term Care Information.[26]

Summary

The challenges and trends are clear: Fiscal pressures from multiple sources will continue to stress the allocation and use of Medicaid LTC expenditures. Medicaid, as the nation's primary funder of LTC services, must be viewed within the larger context of health care spending priorities and the complex financial picture of U.S. health care expenditures. States, some more than others, are actively engaged in demonstration initiatives to control LTC expenditures while maintaining and/or increasing quality. Within the current Medicaid structure, there are challenges to the allocation of resources between HCBS and institutional LTC. New public/private partnerships are being explored to better align LTC services with the needs and preferences of people needing care.

Given state's challenging fiscal environment, transforming Medicaid's LTC programs is one of the urgent priorities. Optimal performance is necessary in each of the following areas:

☑ **Enrollment and Verification**
States should consider optimal enrollment and verification programs.

☑ **Program Structure**
States should consider Medicaid program structure.

☑ **Medical Management**
States should consider the medical management program in place.

☑ **Infrastructure**
States should consider the infrastructure of Medicaid programs.

☑ **Budgeting**
States should consider the budgeting for Medicaid programs.

☑ **Compliance**
States should consider implementing a compliance program to ensure providers are following federal and state regulations governing the Medicaid program. Such a program could include auditing procedures, training for employees and instructions for reporting violations.

☑ **Medicaid and Medicare Alignment**
State should consider closer coordination of Medicaid and Medicare benefits and services for dually eligible beneficiaries to streamline case management activities.

☑ **Tiered Waivers**
In recent years, there have been many changes to the Medicaid waiver program. States should confirm that appropriate waiver limits have been implemented and reviewed with enrollees.

☑ **Federal Match**
States should ensure they are getting the maximum federal match against their state funds. States should also remember that the temporarily higher American Recovery and Reinvestment Act federal match rates expire January 1, 2011, after which states will have to use a greater portion of state funds to cover Medicaid expenditures.

☑ **Centralized Case Management**
States should consider having optimal, centralized case management.

25 Ibid

26 National Clearinghouse for Long-Term Care, http://www.longtermcare.gov/LTC/Main_Site/index.aspx. Accessed March 6, 2010.

Implications

An assessment of the current state of Medicaid's LTC program generates four important questions:

- Might U.S. states partner with the private sector in accelerating transformation efforts? Likely this will be necessary in most states, as the infrastructure and competences required might not be readily available within existing state agencies and/or departments.
- Might states need to "sell" the idea of paying closer attention to Medicaid LTC to legislators and the voting public? Yes. It is a complex topic and prone to misinformation and the political process.
- Might states see a permanent solution to their LTC challenges in the health care reform bill? No. The bill's impact on the LTC population is nominal and additional federal funding not likely, given the government's fiscal constraints.
- Might states wait and see what happens rather than act now? No. Medicaid LTC is one of the most urgent health care problems for most states. Failure to innovate with medical and administrative management initiatives will likely result in increasing costs, voter discontent, poor quality and fiscal challenges.

Medicaid LTC is a burning platform. It needs attention. It cannot wait.

Appendix

The following four scenarios were chosen for illustrative purposes only, as examples of possible outcomes:

1. **Base Case:** Current state of Medicaid expenditures trends without any intervention. This presents the burning platform based on current trends.
2. **Best Case:** Current base case, but with actions that resulted in a five percent cost savings to Medicaid from innovative solutions to bend the curve. (A five percent cost savings target was chosen to highlight the Medicaid cost trend impacts that typical/existing approaches have achieved in the past.)
3. **Worst Case:** Presents the impact if current trends included a 40 percent growth in Medicaid membership due to increased Medicaid access via legislative mandates. (A 40 percent growth in Medicaid membership was chosen to provide an illustration of an extremely high increase in enrollment.)
4. **Likely Case:** Similar to Scenario 3, but instead includes a 20 percent growth in Medicaid membership instead of 40 percent. (A 20 percent growth in Medicaid membership was chosen based on analysis of factors likely to drive enrollment.)

Data sources & key assumptions included:

- **Annual State Operating Budget** – Individual state websites and employees; National Center for State Courts for 2002-2008 and projected to 2030 based on historical averages.
- **Medicaid total expenditure and membership and nursing facility (NF) expenditure** – CMS National Health Expenditure and projected based on the CMS 2008 Medicaid Report.
- **Medicaid LTC expenditure** – Kaiser Family Foundation (www.statehealthfacts.org). Projections based on the CMS 2008 Medicaid Report.
- **Medicaid LTC membership** – AARP. Projections set equal to Medicaid members' trend. Note CMS 2008 Medicaid report factors in population demographics.
- **State LTC and NF expenditure** – Medicaid's LTC and NF expenditures multiplied by one minus the Federal Medical Assistance Percentages (FMAP).
- **NF membership** – UCSF's Department of Social and Behavioral Sciences study. Projections used the CMS 2008 Medicaid Report and were adjusted for an increasing shift of NF residents out of NF and into other LTC facilities (based on The Lewin Group's study, "Can Home and Community-based Services be Expanded Without Busting the Budget?") and for the aging Baby Boomer population (based on U.S. Census data).

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We'd like to thank the following individuals for their contribution to conducting research for this report:

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Acknowledgements

We wish to thank Jennifer Bohn, Kerry Iseman and the many others who contributed their ideas and insights during the design, analysis and reporting stages of this project.

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Secretary Sebelius Questions for the Record
House Committee on Energy and Commerce Subcommittee on Health
March 3, 2011

The Honorable Joe Pitts

1. Congress gave CMS the authority to establish a quality reporting system for ambulatory surgery centers in 2006, but CMS has not utilized that authority. The ASC industry came together in 2005 to form the ASC Quality Collaborative in anticipation of a quality reporting system and has developed six measures that have been endorsed by the National Quality Forum. CMS indicated that it hoped to issue a proposed rule in 2011 to establish an ASC quality reporting program. Can you confirm that the agency still intends to issue a proposal? And given the recent focus by the Administration on eliminating overly burdensome regulations will you assure us that CMS will work with the industry to ensure that they propose a system that will allow broad participation by ASCs regardless of their size or level of sophistication? Obviously a working quality reporting system should be in operation for several years before CMS can implement a value-based purchasing system as called for in PPACA.

Answer: The Centers for Medicare & Medicaid Services (CMS) is committed to improving care for Medicare beneficiaries and for all Americans through simultaneous pursuit of three aims: better care for individual patients, better health for populations, and reduced per-capita costs through improvements in the efficiency and quality of care. Quality reporting and value-based purchasing programs (VBP) are essential elements in accomplishing these goals, and we believe that promoting high quality care in the ASC setting through quality reporting and, eventually, ASC value-based purchasing is highly desirable and would be consistent with the agency's efforts in other payment systems.

In its proposed policy changes for ASCs for calendar year (CY) 2012, CMS is proposing to use its authority to implement a quality reporting program for ASCs. To allow the ASC industry time to plan for future measurement requirements and to ensure greater participation, CMS is proposing measures for three subsequent payment determinations. These measures include 8 proposed quality measures to be reported by ASCs beginning in CY 2012 for CY 2014 payment determination, 2 additional measures for the CY 2015 payment determination, and one additional measure for the CY 2016 payment determination. CMS is currently soliciting comments regarding these proposed measures, and will carefully consider all comments from the ASC industry and the general public regarding this important new quality reporting system. The CMS is committed to taking necessary steps to encourage broad participation in its ASC quality reporting system while concurrently building a robust set of quality measures to measure and improve the quality of care furnished in ASCs.

2. According to the Comprehensive Error Rate Testing Report, 7.8% of fee-for-service Medicare claims were paid improperly in Fiscal Year 2009. That's $24.1 billion in improper payments in just one year in Medicare alone. The Medicare Recovery Audit Program is designed to identify and recoup these erroneous payments.

a. What is CMS's recovery goal for each of the next three years?

Answer: As required under statute (the Improper Payments Information Act (IPIA), as amended by the Improper Payments Elimination and Recovery Act (IPERA)), CMS measures and estimates an improper payment rate for our programs on an annual basis. The IPIA uses the term "improper payment" to describe any payment that should not have been made or that was made in an incorrect amount. These billing anomalies can result from a variety of circumstances, including: 1) services with no documentation, 2) services with insufficient documentation, 3) incorrectly coded claims, or 4) services provided that were not determined "reasonable and necessary." Further, improper payments do not always represent an unnecessary loss of Medicare, Medicaid, or CHIP funds. They are usually not fraudulent nor necessarily payments for inappropriate claims; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service.

In keeping with the requirements of the IPIA, each year as part of the annual financial audit CMS releases an estimated Medicare fee-for-service "improper payment" rate, an estimated improper payment amount, and improper payment targets for future performance. CMS implements aggressive corrective actions to reduce improper payments and support the submission of correct claims. In addition, CMS recently implemented the national Recovery Audit program following the successful completion of a three-year demonstration. Recovery Auditors review already paid claims, and are one tool that CMS uses to reduce improper payments and correct the subset of "improper payments" that are actual payment errors. Each Recovery Audit contractor is responsible for identifying overpayments and underpayments based on a review of Medicare fee-for-service (FFS) submitted and paid claims.

In the Recovery Audit Contractor demonstration (March 2005 – March 2008), the recovery audit contractors corrected $1.03 billion in improper payments. ($992.7 million in recovered overpayments and $37.8 million in identified underpayments.)

CMS implemented the national RAC program in October 2009. As of March 2011, the National Recovery Audit Program corrected $365.8 million in improper payments. ($313.2 million in recovered overpayments and $52.6 million in indentified underpayments.)

This information is available at the CMS website at http://www.cms.gov/Recovery-Audit-Program/Downloads/FFSNewsletter.pdf.

CMS is committed to correcting all payments made in error in Federal health programs. CMS is working with the Recovery Auditors to ensure that they are making accurate decisions, and are not overburdening the physician, supplier, and provider community as the identify and collect overpayments and underpayments made in the Medicare FFS program. CMS has also implemented corrective actions across the Medicare program as a result of suggestions and lessons learned from the Recovery Auditors; these corrective actions have improved the Medicare program and resulted in reduced improper payments in future years.

b. Also, what expectations do you have for the rollout of the Medicaid Recovery Audit Contractor (RAC) program?

Answer: For Medicaid, CMS supports States' implementation of RACs in the Medicaid program and has provided guidance to States in the form of a letter to State Medicaid Directors (October 1, 2010) and a Notice of Proposed Rulemaking (published November 10, 2010). CMS expects to publish final regulations regarding the use of RACs in the Medicaid program later this year.

In addition, CMS has provided significant technical assistance to States through all-State calls and webinars and has begun the coordination with States that have RAC contracts in place, as required by the statute. CMS intends to grant States flexibility in the design of their RAC programs to the extent possible while still meeting the statutory requirement that States contract with RACs "in the same manner as" the Secretary contracts with Medicare RACs under section 1893(h) of the Social Security Act.

3. According to press reports, Planned Parenthood has mandated that each of its affiliates provide abortions within the next two years if they wish to maintain affiliate status. If President Obama's goal is to reduce the number of abortions, why is HHS providing hundreds of millions of dollars to an organization that is determined to increase its revenue by increasing the number of abortions it performs?

Answer: Federal funding cannot be used for abortion, except in cases of rape, incest or endangerment of the woman's life. Federal guidelines require all State Medicaid programs to cover family planning services and supplies for individuals of child bearing age, and Planned Parenthood clinics provide these services to over a million Medicaid beneficiaries annually. In addition, many Planned Parenthood clinics receive Federal funding under the Title X program, which provides primary reproductive health services -- including cervical cancer screening, pelvic exams, as well as related patient education and counseling. Prohibiting Federal funding for these critical health care services could create unnecessary barriers to family planning and other services for vulnerable Americans.

The Honorable Fred Upton

1. Section 6301 of the Patient Protection and Affordable Care Act (PPACA) established the Patient-Centered Outcomes Research Institute (PCORI). This supposedly independent Institute is funded through mandatory federal government appropriations, taking money from Medicare and taxing private health insurance plans. How much money will PCORI receive each year?

Answer: The Patient-Centered Outcomes Research Institute (PCORI) was established by the Affordable Care Act to assist patients, clinicians, purchasers and policy makers in making informed health care decisions through the availability of relevant high quality evidence evaluating and comparing the clinical effectiveness, risks, and benefits of different medical treatments, services and strategies.

The new Institute will be funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF) established by the Affordable Care Act which appropriates specific amounts in fiscal years 2010 through 2012. Funding levels for FY 2013 through FY 2019 represent estimates. Beginning in FY 2013, in addition to appropriations, funds available in the PCORTF will include transfers from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, and fees applied to health insurance and self insured plans. Of the funds appropriated and credited to the PCORTF each year, 80% will be transferred to PCORI. Figures for FY 2013 through FY 2019 were derived using amounts included within the FY 2012 President's Budget Analytical Perspectives supplemental materials table on Federal programs by agency and account.

Fiscal Year	Amount Available To PCORI
2010	$10 million
2011	$40 million
2012	$120 million
2013	$314 million
2014	$522 million
2015	$553 million
2016	$589 million
2017	$623 million
2018	$654 million
2019	$688 million

2. Even though the PCORI Institute is supposedly independent, it must give preference to NIH and AHRQ in awarding research contracts and it must give 20 percent of its funding to HHS so the department can disseminate its findings. How much money do you expect the Department to receive each year from PCORI and its trust fund?

Answer: The Patient-Centered Outcomes Research Trust Fund (PCORTF) was established by the Affordable Care Act to fund the independent Patient-Centered Outcomes Research Institute (PCORI) and to provide funding to HHS to build data and research capacity, and to disseminate

research findings from the Institute as well as other Government funded research related to clinical comparative effectiveness research. Of the funds appropriated and credited to the PCORTF each year, 80% will be transferred to the new Institute, and 20% will be transferred to HHS and directed to the Secretary and the Agency for Healthcare Research and Quality. For fiscal years 2011 through 2019, the Affordable Care Act transfers funds to HHS, directly from the PCORTF:

Fiscal Year	Amount For Transfer To HHS
2011	$10 million
2012	$30 million
2013	$79 million
2014	$130 million
2015	$138 million
2016	$147 million
2017	$156 million
2018	$164 million
2019	$172 million

Funding levels for FY 2013 through FY 2019 represent estimates. Beginning in FY 2013, funds available in the PCORTF will include the $150 million per year in appropriations, transfers from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, and fees applied to health insurance and self insured plans. Figures for FY 2013 through FY 2019 were derived using amounts included within the FY 2012 President's Budget Analytical Perspectives supplemental materials table on Federal programs by agency and account.

3. Secretary Sebelius, Section 1005 of the Health Care and Education Reconciliation Act (HCERA) provides HHS with a broad $1 billion implementation fund to administer PPACA and HCERA. Can you provide the committee with estimates of how much of this fund has been spent and on what activities?

Answer: The Affordable Care Act appropriated $1 billion for implementation of health reform. As of December 31, 2010:

- HHS has obligated approximately $125 million. $107 million of this amount was obligated in FY 2010 and $18 million was obligated in the first quarter of FY 2011.
- HHS has thus far provided approximately $66 million to agencies outside HHS, $61 million to Treasury and $5 million to OPM; of this amount $36 million has been obligated.
- In total, approximately $252 million has been provided to agencies within and outside of HHS and approximately $161 million of that amount has been obligated.

4. Of the $1 billion implementation fund, how much money has HHS transferred to IRS? For what purpose?

Answer: The Department of Treasury required funding to implement multiple tax changes, including the Small Business Tax Credit, expanded adoption credit, W-2 changes for reporting the cost of employer-sponsored health care coverage, excise tax on indoor tanning services, charitable hospital requirements, annual fee on branded prescription pharmaceutical manufacturers and importers, and planning for exchanges. As of December 31, 2010, $61 million has been provided to the Department of Treasury.

5. Secretary Sebelius, PPACA authorizes your department to issue regulations regarding an essential benefits package. This rule will place new federal mandates on nearly every health plan in America. Can you tell us when HHS plans on issuing its initial regulation?

Answer: The law calls on HHS to define the essential health benefits, but this will be a team effort. As we develop regulations on this issue, we will consider a report on benefits currently offered by employers, which was provided earlier this spring by the Department of Labor. We have also asked the Institute of Medicine (IOM) for recommendations on a process for defining and updating these benefits. The IOM has a long history of providing independent, objective expert guidance to federal agencies and we look forward to reviewing their report in September.

Most importantly, the Department looks forward to hearing from the American people, doctors, nurses, Members of Congress and other interested stakeholders. Beginning this fall, HHS will launch an effort informed by the Department of Labor report and IOM's recommendations to collect public comment and hear directly from Americans who are interested in sharing their thoughts on this important issue. We are confident that this process will insure transparency and result as a definition of essential health benefits that will strengthen our health care system.

6. Under the President's announcement on March 1 regarding state innovation waivers, would the individuals and companies in those states be exempt from all the new taxes called for in the bill. For example, if New Jersey opted out, would medical device companies based in New Jersey have to pay the new medical device tax or would workers be subject to the new tax on employer sponsored health care plans that goes into effect in 2018?

Answer: Innovation Waivers offer States flexibility while ensuring that Americans, no matter where they live, have access to affordable, high-quality health insurance. The Affordable Care Act provides that a State may apply to waive certain provisions of the ACA, including those relating to qualified health plans, Exchanges, premium tax credits, cost-sharing reductions, the individual responsibility requirement, and shared responsibility for employers. To provide flexibility to States, the decision to include any or all of these provisions in a waiver request is up to the applying State. If a waiver is approved, the State can use funds that would have gone towards federal credits and subsidies to implement its own plan for expanding health care coverage.

7. Section 9001 of PPACA imposes a tax on certain employer sponsored health insurance plans. However this tax is delayed until 2018. Can you explain why the Administration advocated delaying this tax for eight years if they felt this was good policy?

Answer: Part of the reason for high and rising insurance costs is that insurers have little incentive to lower their premiums. That is why the law includes a tax on health insurers and third-party administrators offering the highest-cost health care plans. CBO has estimated that this policy will reduce premiums considerably over time.

The effective date of 2018 provides important transition time for high-cost plans to become more efficient. To the degree that health costs rise unexpectedly quickly between now and 2018, the initial threshold would be adjusted upwards automatically. To ensure that the tax targets the plans with the most generous benefits rather than simply plans with high costs, the law includes an adjustment for firms whose health costs are higher due to the age or gender of their workers and for high-risk occupations such as "first responders."

8. Do you believe that uninsured, low-income individuals should be allowed to access the subsidies provided under PPACA to purchase a health plan that meets their needs or do you believe such an individual should only have the option of Medicaid? Similarly, do you believe individuals not eligible for Medicaid should have the option to buy coverage on the individual market, outside the Exchanges, and still benefit from the available tax credits?

Answer: The Affordable Care Act provides that, beginning January 1, 2014, individuals under the age of 65 with incomes up to 133 percent of the Federal poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible for Medicaid. All newly eligible individuals will be guaranteed a benchmark benefit package that provides the essential health benefits.

Also effective January 1, 2014, low-income individuals under age 65 who are not eligible for other coverage (for example, Medicare, Medicaid, or affordable employer-sponsored coverage), may receive tax credits and cost-sharing reductions to use to purchase insurance coverage through the health insurance Exchanges. These eligible individuals will also be guaranteed a benchmark benefit package that provides the essential health benefits.

Under the Affordable Care Act, individuals eligible for Medicaid are not eligible for premium tax credits, and those eligible for premium tax credits may only use them to help cover the cost of insurance purchased through an Exchange.

9. Secretary Sebelius, your Department's FY 2012 budget requested $120 million to begin the implementation of the CLASS Act program. You have in the past claimed that the class program in its current form is "totally unsustainable." In your February 15th testimony before the Senate Finance Committee, you stated that the Administration will attempt to implement changes to the CLASS program to make it financially solvent before beginning program operations. Can you please explain why the administration requested $120 million for outreach and enrollment efforts in FY 2012 when you clearly do not believe the program is sustainable? If outreach and enrollment activities are intended to start in FY 2012, how will you describe a program you currently describe as unsustainable?

Answer: As you know, I am required to determine whether the program is actuarially sound before proceeding to offer insurance to consumers. Our program development work is guided by that principle. We will not implement the program unless it is solvent and sustainable, as required by the statute.

The President's FY 2012 Budget requests $120 million in administrative funding for the CLASS program, including significant investments for the development of an IT system and education and outreach to potential participants and employers.

CLASS requires funds from a discretionary appropriation in FY 2012 to bridge the period between FY 2011 when funding is covered under Section 1005 of P.L. 111-152 and the point at which administrative funding can be drawn statutorily from premiums received.

For FY 2010 and FY 2011, no Administration on Aging funding is being used to administer CLASS. The program's expenses in these years are being funded entirely by the Health Reform Implementation Fund.

10. Follow up: Can you please provide more information on the changes you believe you will need to make to the program in order to make it more sustainable and your intended budget and timeline for doing so?

Answer: As you know, I am required to determine whether the program is actuarially sound before proceeding to offer insurance to consumers. Our program development work is guided by that principle. We will not implement the program unless it is solvent and sustainable, as required by the statute. There are certain statutory requirements for the CLASS program that cannot be adjusted to enhance program stability. For example, CLASS must be a voluntary program, with no medical underwriting, and benefits must be fully paid for with premiums collected. However, I have publicly discussed other improvements currently being considered that could enhance program stability over the 75-year period required by the law. These include increasing the employment and earnings requirements, indexing premiums to rise along with benefits, and minimizing the possibility that people will "game" the rules e.g. serially skipping payments and re-enrolling at a later time while facing minimal or no penalty.

The Department will analyze each option on its merits and its consistency with the law and its intent. The law directs me to designate a benefit plan by October 2012, after developing three alternative benefit plans, in consultation with actuaries and other experts and presenting these plans to an advisory council composed of consumers, caregivers, and individuals with technical expertise.

11. Why did you move the Office of Consumer Information and Insurance Oversight, which you put in charge of regulating private insurance, to CMS which is responsible for government financed health care programs, yet you moved the CLASS Act, a government financed health care program to the Administration on Aging?

Answer: The Administration on Aging's mission is to help older Americans, including those with disabilities, stay in their home through long-term services and supports. The

Administration on Aging operates a national network of Aging and Disability Resource Centers (ADRCs) which serve individuals of all ages who experience disabilities. In addition, the Administration on Aging runs the Long-Term Care Clearinghouse which provides information on the need for long-term services and supports—the misconception is that Medicare covers these services—and on the necessity to plan ahead to pay for potential needs.

12. In preemies, RSV is a major health concern. It is one of the leading causes of sickness and re-hospitalization for preemies. I understand that, last December, the CDC's Advisory Committee on Immunization Practices (ACIP) decided it would disband a working group on RSV which was initially formed to create guidelines for RSV Prophylaxis. I also have learned that the CDC intends to move forward on a cost effectiveness study of RSV Prophylaxis. I am anxious about any government study that focuses exclusively on cost effectiveness, especially one that lacks transparency and is done without any regard to multi-disciplinary cross-functional input. This could result in negative consequences for one of our most vulnerable populations. As you know, coverage determinations are often made on these unsubstantiated studies. I would like to know the following:

a. What is ACIPs role in this analysis?

Answer: The ACIP is not playing a role in this analysis.

Several years ago, a newer product for RSV prevention, Motavizumab, entered into clinical trials, and on the basis of those trials, the manufacturer applied for licensure through FDA. At that time, the Advisory Committee on Immunization Practices (ACIP) set up a work group to develop recommendations for use of this new product, anticipating that it could receive FDA licensure. However, in June 2010, an FDA panel reviewing the manufacturer's submission gave the product an unfavorable review. Based on this, the manufacturer later decided to discontinue the product's development. Because ACIP's mandate is restricted to FDA-licensed products, the committee elected to disband the work group. When the manufacturer request for the license was pulled, ACIP stopped its work but the CDC RSV experts agreed to continue to look at the cost-effectiveness of RSV prophylaxis overall.

b. What is the timeline for this study?

Answer: It is anticipated that the analysis will be completed over the summer of 2011 and submitted for publication within the following year.

c. Who is taking lead at the CDC?

Answer: Epidemiologists and public health experts in respiratory viruses located with CDC's Division of Viral Diseases are taking the lead for this analysis.

d. What does the CDC intend to do with the final analysis?

Answer: Currently, a group of CDC RSV subject matter experts is conducting an analysis to look at the amount and nature of disease caused by RSV, the cost of that illness as well as the

costs of RSV prevention methods, the amount of disease that can potentially be prevented (e.g., with good uptake of the interventions), and the potential savings that result from that prevention. CDC anticipates that the results of this analysis will be widely available to the scientific community through a peer-reviewed journal publication. In addition, the CDC subject matter experts continue their usual surveillance activities which involve collection of epidemiologic data on RSV to better understand the disease burden, risk factors for severe disease and the impact of current prevention methods and improved methods of RSV prevention including collaborations on vaccine development.

e. What is the impetus for such an analysis?

Answer: RSV sickens a tremendous number of American infants every year, resulting in tens of thousands of hospitalizations and 200–500 infant deaths. There is currently no licensed vaccine against RSV, though several vaccines are in early-stage development. CDC has a multifaceted program to investigate RSV, to better assess the amount of disease caused by the virus, improve laboratory methods for the diagnosis of RSV and provide a better understanding of the risk factors for severe RSV disease. CDC has played a key role in monitoring the disease and in documenting the burden of disease caused by RSV, including by collaborating with academic institutions in three U.S. states to provide the most comprehensive assessment of how RSV affects children every year in this country. CDC also provides critical data on the timing of RSV disease around the United States (i.e., seasonality) that is used by state health departments and practitioners to guide the timing for which RSV prophylaxis is given.

13. In light of the importance of the current Medicare as secondary payer policy for end-stage-renal disease (ESRD) patients (a policy which is designed to facilitate a private-public partnership for the treatment of ESRD), what specific steps does HHS plan to take to ensure that the existing ESRD secondary payer rules are not discarded (or become less relevant) under the Health Insurance Exchanges and ESRD beneficiaries still receive their care through a mix of private and public payers? Please be specific and outline HHS's position on the Medicare as secondary payer issue under the Exchanges (whether it should be maintained) and how it intends to conform the definitions for plans participating in the Exchange so that they maintain their MSP status?

Answer: The Affordable Care Act does not change existing Medicare secondary payer rules should ESRD beneficiaries become enrolled in a qualified health plan through an Exchange. Medicare ESRD secondary payer rules govern which payer has primary and secondary responsibility for paying claims when a beneficiary has other non-Medicare (including private) health insurance coverage. This has always been and will continue to be a plan to plan relationship and health insurance Exchanges do not change this dynamic.

14. Can you please provide the Committee a list of all the reports produced in the last year by the Office of the Assistant Secretary for Planning and Evaluation?

Answer: In the past year, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) has produced the following reports to Congress: Performance Improvement Report; Strategic Plan; Elder Abuse Report to Congress; the Interagency Working Group on Youth

Programs' Progress Report to the President; and the Report to the Congress on a Study of the Large Group Market. All of these reports can be found on their website, www.aspe.hhs.gov. Additionally, ASPE conducts research and evaluation studies, develops policy analyses, and estimates the cost and benefits of policy alternatives under consideration by the Department.

15. Can you please provide the Committee with the specific grants and descriptions of each grant that have been awarded with funds from the Prevention and Public Health Fund created under section 4002 of PPACA?

Answer: Attached to this document are the three charts provided to your committee on April 4, 2011 which provide specific information on grants funded through the Prevention and Public Health Fund in FY 2010.

The Honorable Cathy McMorris Rodgers

1. Welcome Secretary Sebelius. I appreciate your willingness to testify. I would like to relay a comment that was passed on to me by a former state official and get your comment. The quotation is "if we [CMS] give you this amount of flexibility, what are we supposed to do; we might lose our jobs because we have nothing to do."

a. Now, I know that we both agree that tax payer dollars should be used judiciously. With respect to Section 1115 Demonstration Waivers, we know that timely waiver responses mean more flexibility and in most cases significant cost savings to states. But, when CMS takes more than eight months to respond to waiver request, it seems to me that this comment and others like them have merit. How do you respond to this?

Answer: We have a longstanding history of working with our partners in the States on their Medicaid waiver requests in the most expeditious timeframe possible. However, we understand that for those outside the CMS-State partnership, our waiver negotiations can often seem opaque. We are currently in the process of implementing section 10201(i) of the Affordable Care Act to make the waiver process more transparent, including the opportunity for public input.

Additionally, the Administration understands the challenges States are facing and we're ready to offer new approaches, listen to new ideas and conduct business with States in ways that are responsive to the severity and immediacy of these challenges. We're taking a number of steps to help States implement changes that will bring efficiencies to their Medicaid programs and improve the quality of care provided. We're developing strategies to offer States waivers, technical support and fast-track ways for them to implement new initiatives – particularly those targeted at ending the fragmented care provided to Medicare-Medicaid beneficiaries, lowering pharmacy costs, increasing coordination, improving patient safety, and improving program integrity. These steps will both strengthen the program over the long run and help States run more efficient Medicaid programs.

We look forward to continuing to work with our partners in the States.

b. How does a $1 billion increase in CMS's budget promote a smaller, smarter government, when by all accounts it seems that CMS is trying to preserve a bloated, inefficient federal government?

Answer: The FY 2012 Budget Request reflects the fact that CMS is assuming responsibility for new authorities and private health insurance protections and coverage that resulted from the Affordable Care Act. To carry out these responsibilities in the most efficient manner, the Department will use CMS's seasoned staff and information technology resources to avoid unnecessary duplication. Additionally, this budget request would allow CMS to modernize and improve its data structure and IT infrastructure, which will better serve providers and beneficiaries and continue to support our important program integrity efforts.

c. Do the proposed program integrity plans address this type of waste? How will you ensure that we are working to ensure the most effective use of funds both at the state and federal level?

Answer: The FY2012 budget makes fighting health care fraud and reducing improper payments a top priority. These efforts will safeguard public funds and send a clear message that fraud and waste in our health care programs will not be tolerated. The President's Budget included $581 million in HCFAC discretionary funds in FY 2012, which have shown in the past a strong return-on-investment (ROI) and successful recoveries to the Trust Funds. CMS' Actuaries have determined that the $581 million, as part of a multi-year investment, is estimated to save $4.6 billion over five years and $10.3 billion over ten years. The increase in funds for FY 2012 will be split among CMS and its law enforcement partners and be used to continue and expand program integrity efforts.

The Honorable Marsha Blackburn

1. According to the Centers for Disease Control and Prevention, the United States ranked 29th in the world in infant mortality in 2004 with more than 28,000 deaths annually to children under one year of age. Preterm birth is a significant factor on the infant mortality rate. It is estimated that in 2005, nearly 70 percent of all infant deaths occurred to preterm infants. Prematurity is also a dramatic cost driver to our healthcare system. The Institute of Medicine estimates that preterm birth costs the United States more than $26 billion annually.

a. What actions are being taken by the Department of Health and Human Services to address and prevent preterm birth?

Answer: Several agencies across HHS have been working to improve outcomes and prevent preterm births, as this public health issue spans a broad range of the health system. CDC's work addresses preterm birth by monitoring trends, sponsoring and conducting research and supporting programs, all of which attempt to address the social and biomedical factors that affect preterm risk. We achieve this through two basic mechanisms: surveillance and research.

Surveillance
CDC's National Center for Health Statistics (NCHS) collects national statistics on prematurity rates using birth certificates and death certificates. This data allows CDC to follow trends, monitor risk factors, and identify variations in rates of preterm births at the state and county levels. When birth certificate information is linked to information on death certificates, CDC is able to look at causes of death for those babies who died during their first year of life. Using data from this linked file, we were able to demonstrate the strong relationship between preterm birth and infant mortality. Each year, CDC's National Center for Health Statistics reports in detail on preterm birth rates across the country and on "preterm-related" infant mortality.

CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) – The surveillance system is an ongoing, state-specific, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy. Through this system, CDC is better able to understand issues such as prenatal care, folic acid to prevent birth defects, obesity, pregnancy weight gain, stressful life events, and physical abuse. For example, an analysis of PRAMS data showed that stressful life events were associated with increased risk of preterm delivery. PRAMS has served to expand the capacity of 37 states and New York City to define and address their health needs and this unique surveillance system is now representative of approximately 75 percent of all births in the United States. It has provided vital information to program managers and decision-makers for development of policy and programs in maternal and infant health.

Research
A complex array of factors interferes with healthy pregnancy outcomes and racial disparities. CDC is investigating changes in healthcare practices that may have caused this increase and the short and long-term consequences of late preterm births. Examples of projects CDC is

working on include:

- A multi-year study to discover the extent to which non-medically-indicated cesarean deliveries or labor inductions contribute to rising preterm birth rates and the impact of non-medically-indicated preterm delivery on neonatal and maternal morbidity.

- CDC conducts studies of the epidemiology and sequelae of late preterm birth using the Massachusetts Pregnancy to Early Life Longitudinally Linked database (PELL). Research on short- and long-term morbidity among late preterm infants is limited and this work will contribute to better understanding of sequelae associated with late preterm births. The following analyses and manuscripts are planned or underway using PELL data:
    - Assess association between late preterm birth and the use of early intervention services.
    - Examine the principal causes of post neonatal morbidity among late preterm infants compared to term infants.

- CDC is funding the American College of Obstetricians and Gynecologists (ACOG) to survey provider knowledge, attitudes, and practices of gestational age dating and late preterm birth. In this partnership, AGOG will conduct a national survey of obstetricians regarding knowledge, attitudes, and practices related to gestational age dating and delivery of late preterm infants. The survey will assess perceived barriers to early and accurate gestational age dating, decision-making strategies for timing delivery, management of spontaneous late preterm labor and delivery, and immediate postpartum management of neonates delivered late preterm. Information collected from this survey will help guide policy efforts and strategies aimed at preventing the rising incidence of late preterm birth.

In addition to the work carried out by CDC, the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), National Institutes of Health, supports a large portfolio of research on preterm birth. A number of investigator-initiated studies are underway, and larger-scale clinical research is often conducted through the NICHD's Maternal Fetal Medicine Units (MFMU) Network. The MFMUs target research to prevent low birth weight and prematurity, and to improve treatment for medical problems associated with preterm birth, including preeclampsia, gestational diabetes, and placenta previa. Moreover, the NICHD supports studies that evaluate programs and treatments to improve the care and outcome of newborns, including infants born preterm and at low, very low, and extremely low birth weight. Many of these studies are conducted through the Neonatal Research Network. Specific areas of focus include sepsis, intraventricular hemorrhage, chronic lung disease, pulmonary hypertension, acute perinatal asphyxia, and nutrition.

Beyond research, CDC works to prevent adverse birth outcomes by encouraging tobacco cessation during (and ideally, prior to) pregnancy. Tobacco use remains a significant preventable cause of low birth weight, preterm birth and of some major birth defects. CDC's efforts include working with state health departments to implement comprehensive tobacco control and prevention programs and assist with smoking cessation programs during pregnancy.

Access to care is another important factor in reducing preterm births, and Medicaid and CHIP are critical health care programs that connect low-income pregnant women to coverage and services that help reduce the risk of preterm birth and improve outcomes through proper and timely prenatal care. On June 24, 2011, the Centers for Medicare & Medicaid Services (CMS) released guidance in the form of a State Medicaid Director's letter on implementation of section 4107 of the Affordable Care Act. This provision provides for Medicaid coverage of comprehensive tobacco cessation services for low-income pregnant women, including both counseling and pharmacotherapy, without cost sharing. Expanding coverage of tobacco cessation services to low-income pregnant women is a significant step to reduce pregnancy complications related to smoking, including preterm birth.

Additionally, HRSA administers the Title V Maternal and Child Health Block Grant. The purpose of the Title V Maternal and Child Health Block Grant is to improve the health of all mothers and children consistent with the applicable health status goals and national health outcomes established by the Department. Specifically noted, among others is, "to reduce infant mortality." To that end, States report on rates of infant mortality and focus efforts on surveillance, research, and intervention relative to the contributing factors which includes preterm birth. Below are just a few examples of how States have incorporated efforts to address preterm births as part of their efforts to improve birth outcomes.

- **Louisiana:** Infant Mortality Reduction Initiatives (IMRI) were established by the state's Maternal and Child Health Agency in each of the 9 regions of Louisiana, including a staff person to coordinate and direct Fetal-Infant Mortality Review with a Case Review Team made up of public and private obstetric and pediatric providers and a Community Action Team made up of local community leaders. The IMRIs have become the regional maternal and infant health infrastructure that conducts needs assessment, strategic planning, and implementation of preventive interventions. Louisiana's Department of Health and Hospitals has funded a new Birth Outcomes Initiative. Louisiana's Maternal and Child Health Agency will work in close collaboration with this initiative to add pre and interconceptional health and late preterm birth prevention approaches to addressing Louisiana's high infant mortality rate.

- **Mississippi:** Low birthweight, preterm birth and preconception care were adopted as the priority needs for the maternal child health programs and the new 5-year cycle of the Title V MCH Block Grant. A measurable state performance indicator has been established for each of the priority issues, a data source identified, and base line data extracted.

- **Kentucky:** Kentucky has a project studying the contextual factors relating to preterm birth in Louisville, KY, in neighborhoods with high populations of African-Americans. In addition, the Appalachian area is a disparate population with high concentrations of poverty and similar contextual factors. The other focus of prematurity prevention for Kentucky is the Late Preterm Births, those occurring between 34 0/7 weeks and 36 6/7 weeks gestation. Kentucky's Healthy Babies are Worth the Wait initiative, with March of Dimes and Johnson and Johnson, has been recognized nationally for emphasizing

strategies to address late preterm births as a population at risk and potentially preventable preterm birth.

While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist in the proportion of pregnancy-related maternal death, in preterm birth, and in infant mortality. Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly defined. Emerging research indicates that environmental, biological and behavioral stressors occurring over the life span of the mother from her earliest life experiences until she delivers her own child may account for a significant portion of the disparities. Moreover, it may take specific interventions consistently provided to several generations before the factors responsible for the disparities in adverse birth outcomes have been overcome.

Today there are at least 520 counties in the US with an infant mortality rate almost 1.5 times the national average (i.e., 520 counties with rates of 10.0 or more infant deaths per 1,000 live births per year.). HRSA's Federal Healthy Start Program provides funding to 104 communities in 38 States, DC, and Puerto Rico, with a high rate of infant mortality, particularly among disproportionately affected, minority populations and in States and communities that do not have adequate resources to address the significant health disparity in infant mortality, low birth weight and preterm birth.

Through a lifespan approach and a focus on the interconception health of women, the Federal Healthy Start Program aims to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions. Begun as a Presidential Initiative in 1991 and authorized under the Children's Health Act of 2000, Healthy Start awards five-year grants and provides technical assistance to communities with exceptionally high rates of infant mortality and other adverse perinatal outcomes such as preterm birth and low birth weight.

Healthy Start fills the gaps in a coordinated manner that other public programs cannot address. In Healthy Start, women are served for two years after delivery or, if a subsequent pregnancy begins within that two-year timeframe, the woman will be followed prenatally and for two years after that pregnancy. Women are provided health promotion, screening and early identifications of risk factors and early interventions to improve future pregnancy outcomes, spacing of pregnancies to at least two years which is known to improve perinatal outcomes. In addition, Healthy Start ensures that there is continuity of care from the moment the mother enters the program, (for some Healthy Start grants, care starts in the preconception period), through her pregnancy and up to two years postpartum. Healthy Start core services address anger, stress, abuse, domestic violence, eating disorders, tobacco, alcohol and drug use that are experienced by many of the high-risk women served by the Healthy Start projects. To ensure high risk women and infants receive coordinated, comprehensive quality services, Healthy Start provides case management which is critical for follow up and referrals of chronic illnesses frequently first detected during pregnancy such as gestational diabetes, pregnancy induced hypertension, cervical dysphasia and precancerous lesions, breast cancer, asthma and other respiratory disorders.

Overall, Healthy Start is successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African-Americans, American Indians/Native Americans). In contrast to the overall national infant mortality rate of 6.7 infant deaths per 1,000 live births, in 2006, the infant mortality rate for Healthy Start participants was 5.7 infant deaths per 1,000 live births. In 2007, the national infant mortality rate rose slightly to 6.75, while the infant mortality rate for Healthy Start participants dropped to 5.1.

In fact, fourteen Healthy Start communities reported no infant deaths among program participants for the past three years (2006-2008): Maricopa County, AZ; Englewood County, CO; Hawaii County, HA; Des Moines, IA; Chicago, IL; Pembroke, NC; Manhattan, NY; Portland, OR; Philadelphia, PA, and San Antonio, TX. An additional eight communities reported no infant deaths over the last two years: (2007-2008).): Blytheville, AR; Mariposa, AZ; Boynton Beach, FL; Louisville, KY; Missouri Bootheel, MO; Tougaloo, MS; Deming, NM, and Bellaire, TX.

b. What major causes of preterm birth have been identified? What, if any, interventions are available to address the causes of preterm birth?

Answer: Preterm birth is a complex disorder, a result of social, behavioral, clinical, and biological risk factors and causes that all contribute to a woman's risk of delivering preterm. Some of the strongest predictors of preterm birth include race, family history, tobacco use and a woman's history of prior preterm delivery. Infection and stress also play a role by eliciting an inflammatory response during pregnancy. NICHD researchers have identified DNA variants in mothers and fetuses that appear to increase the risk for preterm labor and delivery. The DNA variants were in genes involved in the regulation of inflammation and in the reglation of the extracellular matrix, the mesh-like material that holds cells within tissues. The current findings add evidence that individual genetic variation may help account for why preterm labor occurs in some pregnancies and not in others. The findings may one day lead to new strategies to identify those at risk for preterm birth, and eventually strategies to help reduce the occurrence of preterm bith among those at risk. *Romero R, et al "Identification of fetal and maternal single nucleotide polymorphisms in candidate genes that predispose to spontaneous preterm labor with intact membranes" SMFM 2010; Abstract 14.*

In January 2010, the NICHD funded the Nulliparous Pregnancy Outcomes Study through the MFMUs to study women whose current pregnancy will lead to their first delivery; the goal is to collect clinical data from a cohort of racially, ethnically, and geographically diverse populations that will allow researchers to better understand the underlying mechanisms, and predict the women at highest risk for preterm birth and related outcomes.

The interconception period (the time between the end of a woman's pregnancy to the beginning of her next pregnancy) is a critical time to modify risk factors, particularly those such as tobacco use, that are casually associated with infant mortality and preterm birth. Interconception healthcare may improve complications from a recent pregnancy and/or prevent the development of preterm birth or a new health problem (obesity, diabetes, depression, and hypertension) in both the woman and her children. Additionally, interconception healthcare provides a valuable

opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

Begun in 2008, the Healthy Start Interconception Care Learning Community Collaborative (ICC LCC) strives to improve the health and well-being of women and infants served by all 104 Healthy Start grants by advancing the quality and effectiveness of women's health during interconception care in each project. Women enrolled in Healthy Start are followed during pregnancy and through two years after pregnancy. The ICC LCC uses the Plan-Do-Study-Act (PDSA) model developed by the Institute for Healthcare Improvement to integrate evidence-based practice and innovative community-driven interventions to improve care and health outcomes in specific topic areas. Current topic areas include Maternal Depression, Family Planning, Case Management, Risk Screening, Primary Care and Healthy Weight. In May 2011, Healthy Start grantees reported out on their second 9-month change cycle and began their third cycle. The third cycle will end in January 2012. Plans to continue and expand the PDSA quality improvement process across additional Healthy Start content areas are being developed.

c. Infant mortality rates for minorities are well-above the national average. What factors have been identified that contribute to this disparity?

Answer: Infant mortality is associated with maternal health, quality and access to healthcare, socioeconomic conditions, and public health practices. In the U.S. infant mortality rates declined throughout the 20th century and in 2006 the infant mortality rate was 6.7 infant deaths per 1,000 live births. However, there remain persistent disparities in infant mortality rates within certain racial/ethnic groups. Among non-Hispanic black women, infant mortality rates are consistently higher compared to non-Hispanic white women. Specific predictors of infant mortality among minority women include higher rates of preterm birth and low birth weight, and lower attainment of maternal education levels (reflective of socioeconomic differences).

Over the last two decades, the Nation's infant mortality rate has dropped by over half, in part due to research supported by the NICHD showing that placing babies on their backs to sleep greatly reduced the risk of Sudden Infant Death Syndrome (SIDS). Nonetheless, infant mortality rates continue to be higher among racial and ethnic minority groups, and further research and health education efforts are continuing to address these issues head-on.

Using studies of SIDS outreach and education, the NICHD discovered that responses to safe sleep messages differ among various communities and ethnicities. Consequently, tailored health education messages have been created, including extensive materials available in Spanish, specially designed materials about SIDS for African American families and communities, and outreach summits designed to train individuals from many communities in SIDS reduction techniques, so that they could go back into their communities to educate other health care providers and families.

The SIDS rate among American Indians (AI) is the highest of any population group in the U.S. and overall is slightly more than double that of whites. The NICHD collaborated with the CDC, the Indian Health Service, and the Aberdeen Area Tribal Chairman's Health Board to study infant mortality among AIs and to identify prenatal and postnatal modifiable risk factors that

would reduce SIDS risk. This project revealed that even one visit by a public health nurse during pregnancy or after birth reduced the infant death rate due to SIDS by one-fifth compared to homes never visited. A mother's binge drinking during the first trimester of pregnancy was associated with an eight-fold increase in her infant dying of SIDS, and infants wearing two or more layers of clothing at night were six times more likely to die.

Additionally, low birth weight (LBW or birth weight less than 2,500 grams), a major contributor to infant mortality, has been dramatically reduced among Healthy Start participants. In 2009, the most recent year for which data are available, the national LBW rate was 8.16 percent which was slightly decreased from 2007's rate of 8.2 percent, the highest level recorded since the early 1970s. Healthy Start projects' 2007 LBW, in contrast to the upward trend in the nation, had reduced LBW to an average rate of 10.3 percent; moreover, in 2009, the LBW rate for Healthy Start projects decreased to 10.1 percent. Healthy Start communities demonstrating remarkable successes in reducing LBW include: *Baltimore Healthy Start,* where the very low birth weight (VLBW or birth weight less than 1,500 grams) rate is 2.0 percent (17 of 852) among Healthy Start enrolled participants (99 percent African-American) with singleton births, compared to a 3.7 percent citywide African-American VLBW rate. The percent of African-American babies born VLBW in Baltimore is now approaching that of white babies citywide VLBW rate of 1.5 percent. *Kalamazoo Healthy, Baby Healthy Start* has reduced the racial disparity in prematurity to the point that black participants have pregnancies that are as healthy, (i.e., full term and normal weight) as their white neighbors.

Another risk factor for infant mortality is late entry into prenatal care. In 2004, the mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy or not at all was 8.35 per 1,000. This rate was 37 percent higher than the rate for infants of mothers who began care in the first trimester. While nationally, 82.8 percent of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for Healthy Start projects was only 41.8 percent for the same period. By 2007, the projects had increased first trimester entry into prenatal care (EPNC entry) to 68.2 percent and in 2009,early prenatal care climbed to 70.9 percent. The *Luna County Healthy Start,* located along the New Mexico-Mexico border, increased the percentage of clients entering care during the first trimester from 69 percent in 2004 to 85.4 percent in 2009. The *Laurens County Heart of Georgia Healthy Start Initiative* increased first trimester entry from 21.6 percent in 2003 to 91.5 percent in 2009.

Another NICHD-funded study identified three principal factors that account for why families fail to place their infants on their backs to sleep: having concerns about an infant choking, having concerns about an infant's comfort, and not receiving a recommendation from a physician to do so. Studies have shown that multiple layers or heavy blankets, and too-warm rooms, even in colder climates, can increase the risk of SIDS.

d. Geography also factors heavily into infant mortality rates. Twenty four states exceed the national average for preterm birth, and twenty three states are responsible for eighty percent of all pre-term births in the United States. Some cities also experience high rates of pre-term birth. For example, Memphis, Tennessee's infant mortality rate is three times higher than that of the United States – the highest rate of any city. The 2005 infant mortality rate in one area of Memphis (the 38108 zip code) was deadlier than that of the

countries of Vietnam, Iran, and El Salvador. What factors have been identified by HHS to explain geographic disparities?

Answer: There are persistent disparities in infant mortality rates within certain racial/ethnic groups. Among non-Hispanic black women, infant mortality rates are consistently higher compared to non-Hispanic white women. Race, family history, and a woman's history of delivering preterm in a previous pregnancy are some of the strongest predictors of preterm birth and infant mortality. With regard to geographic disparities in infant mortality across the United States, rates are generally higher in the South and Midwest and lower elsewhere. These differences can be attributed to lack of access to care and a higher concentration of women at highest risk in these regions. In addition to use of prenatal care and access to primary and obstetric care, geographic differences (state or city disparities) in infant mortality rates may partly be due to differences in smoking during pregnancy and socioeconomic status. The activities being conducted by CDC addressing infant mortality and preterm birth attempt to include women from different racial/ethnic backgrounds and geographic areas to try and address some of these issues.

Geographic disparities can also be explained in part by the densities of different population groups within a geographic location. As factors for racial and ethnic disparities are elucidated so, too, will some of the geographic disparities.

Scientists agree that people who live in areas with polluted air tend to have more health issues, and areas with higher air pollution also tend to have high population densities, low income levels, and high crime rates, all of which could negatively affect health. Children may be more vulnerable to some environmental pollutants than are adults due to their size and growth. NICHD-supported researchers showed a causal link between some types of air pollution and changes in infant death rates, suggesting that babies who live in areas with clean air have a greater chance of living until their first birthday.

e. What interventions have been successful in reducing the rate of preterm birth?

Answer: A National Institutes of Health (NIH) study has found that progesterone, a naturally occurring hormone, reduced the rate of preterm birth before the 33rd week of pregnancy by 45 percent among one category of at risk women- those with a previous preterm delivery and those at risk for preterm birth. CDC worked collaboratively with NIH on this study. *Progesterone Reduces Rate of Early Preterm Birth in at-Risk Women, Study Suggests Science Daily (Apr. 6, 2011).*

In addition, a Phase III NICHD intramural study, conducted in collaboration with Columbia Laboratories, found that a progesterone gel treatment reduced the rate of preterm birth before the 33rd week of pregnancy by 45 percent among one category of at risk women. The women in the study had a short cervix, which is known to increase the risk for preterm birth. Differences in the rate of preterm birth were also seen in births before 28 and 35 weeks of pregnancy. The study also found that infants born to women who had received treatment with the progesterone gel were less likely to develop respiratory distress syndrome, a breathing complication occurring in preterm infants. Columbia Laboratories is planning to file a New Drug Application this year.

To help ensure that as new research findings become available, they are disseminated quickly through the health care provider community, the NICHD launched the National Child and Maternal Health Education Program with 32 partners in 2009 to provide a forum for reviewing and conveying new information. The program's first focus area is late preterm birth; recently, a Continuing Education program, entitled *Raising Awareness: Late Preterm Birth and Non-Medically Indicated Inductions Prior to 39 Weeks,* was published to help inform the practice of providers.

f. What research is being conducted on preterm birth and infant mortality? What is HHS learning from that research?

Answer: CDC is involved in a number of investigations to evaluate the socioeconomic, clinical, biologic and genetic factors associated with preterm birth in collaboration with states, university researchers, and partners in health care to understand why preterm births occur and what can be done to help prevent them. Examples of projects CDC is working on include:

- A multi-year study to discover the extent to which non-medically-indicated cesarean deliveries or labor inductions contribute to rising preterm birth rates and the impact of non-medically-indicated preterm delivery on neonatal and maternal morbidity.

- CDC conducts studies of the epidemiology and sequelae of late preterm birth using the Massachusetts Pregnancy to Early Life Longitudinally Linked database (PELL). Research on short- and long-term morbidity among late preterm infants is limited and this work will contribute to better understanding of sequelae associated with late preterm births. The following analyses and manuscripts are planned or underway using PELL data:
    - Assess association between late preterm birth and the use of early intervention services.
    - Examine the principal causes of post neonatal morbidity among late preterm infants compared to term infants.

- CDC is funding the American College of Obstetricians and Gynecologists (ACOG) to survey provider knowledge, attitudes, and practices of gestational age dating and late preterm birth. In this partnership, AGOG will conduct a national survey of obstetricians regarding knowledge, attitudes, and practices related to gestational age dating and delivery of late preterm infants. The survey will assess perceived barriers to early and accurate gestational age dating, decision-making strategies for timing delivery, management of spontaneous late preterm labor and delivery, and immediate postpartum management of neonates delivered late preterm. Information collected from this survey will help guide policy efforts and strategies aimed at preventing the rising incidence of late preterm birth.

- CDC is now funding Vitamin D deficiency research using information collected from women and their infants as well as stored maternal blood. Vitamin D levels in maternal

blood will be assessed in an effort to discover the nature of the relationship between vitamin D levels and preterm birth.

- Birth certificates provide the only national data source with which to conduct preterm delivery surveillance. Accurate recording of gestational age on these certificates is critical to calculate the rate of preterm delivery and better understand the impact of preterm birth and follow trends. CDC is conducting a project to identify ways to improve quality of gestational age data collected and entered into birth certificate records working with hospital personnel responsible for completing the birth certificate.

Preterm labor and preterm delivery remain a predominant scientific topic within maternal and child health and represent the primary cause of neonatal mortality with significant short- and long-term morbidities for those who survive. A major study supported by the NICHD is underway to enhance understanding of preterm birth in first-time mothers, a group with a high and growing rate of preterm births. Moreover, the NICHD will continue to support studies on the management of the preterm infant, especially through the Neonatal Research Network.

Recent findings include:

- An investigation into whether a continuous positive airway pressure machine is as effective for preterm infants as a ventilator showed that a lower target range of oxygenation resulted in an increase in infant mortality, although it substantially decreased severe retinopathy among survivors. This information is valuable in making treatment decisions, since lower target range of oxygen saturation is increasingly being advocated to prevent retinopathy of prematurity.
- Researchers have identified DNA variants in mothers and fetuses that appear to increase the risk for preterm labor and delivery. This evidence shows that individual genetic variation may help account for why preterm labor occurs in some pregnancies and not in others, and possibly lead to new strategies to identify those at risk for preterm birth.
- Omega-3 supplementation was found to offer no additional benefit in reducing preterm birth among women who were already receiving injections of 17 alpha-hydroxyprogesterone because of their history of previous preterm birth. The MFMU Network is now conducting a study to look at whether 17-P is effective in preventing preterm birth in women with shortened cervices, a common condition thought to make preterm birth more likely.

The Honorable Michael Burgess

1. As you are aware, Judge Vinson of the 11th Circuit ruled the individual mandate in PPACA unconstitutional and stuck down the law and said, "When a court issues a declaratory judgment against federal officials, the declaratory judgment is the functional equivalent of an injunction." I understand the judge has since issued a stay on his ruling and the Department of Justice has filed an appeal.

First, when can I expect a full answer to my letter that I wrote to you on this issue? Second, for the record, will the department continue to implement the law in the face of injunction?

Answer: We strongly believe – as a number of federal courts have found – that this law is constitutional. There is clear and well-established legal precedent that Congress acted within its constitutional authority in passing the Affordable Care Act and we are confident that we will ultimately prevail on appeal.

2. Section 4101(a) of PPACA provided $50 million in mandatory spending for school based health centers through the year 2013. However, these grants are for construction and there is an express prohibition on these funds being used to provide health services. Section 4101(b) of PPACA created a new discretionary grant program for school based health centers to provide health care services. Did the President's budget request funds for the school based health center grant program created under 4101 (b) of PPACA? Why?

Answer: While the FY 2012 Budget does not include targeted funding for the operation of school-based health centers under Section 4101(b) of the Affordable Care Act (ACA), it does include $3.2 billion (including $1.2 billion available through the ACA) for the operation of health centers, which can use these funds to operate school-based health centers.

3. Section 6001 of PPACA restricts the ability of physician owned hospitals expand or build new additions. In my home state of Texas, physician owned hospitals consistently rank at the top. This section has stopped or jeopardized the construction or expansion of approximately 100 hospitals. It is estimated these facilities could currently be providing economic relief in the form of $200 million in tax revenue and 30,000 jobs to local communities. With more Americans covered under PPACA, how do you justify stifling the growth of these facilities which can offer essential care and eliminating jobs?

Answer: In the Affordable Care Act, Congress limited the ability of physician-owned hospitals to expand facility capacity beyond that in place as of March 23, 2010 and still qualify for the rural provider and whole hospital exceptions to the physician self-referral law. We issued regulations on the new statutory mandate in the CY 2011 Outpatient Prospective Payment Final Rule, which was published in November 2010. Those regulations closely mirror the statute.

In addition, the Affordable Care Act requires CMS to implement an exception process to the expansion prohibition for hospitals meeting certain criteria, such as hospitals treating a high number of Medicaid patients. The exception process will provide individuals in the community where the hospital is located an opportunity to provide input on the hospital's request for an exception.

The Affordable Care Act requires us to issue regulations on the exception process by January 1, 2012, and we are on target to meet this deadline. A proposed process by which providers may apply for an exception was included in the CY 2012 Outpatient Prospective Payment System proposed rule, which went on display at the Office of the Federal Register on July 1, 2011, and will be published on July 18, 2011. The proposed exception process closely mirrors the statutory criteria. CMS will accept comments on the proposed rule until August 31, 2011, and will respond to comments in a final rule to be issued by November 1, 2011.

We encourage providers who are unclear as to how this provision relates to the facts and circumstances of their own facility's expansion to submit an advisory opinion request to CMS for further clarification.

4. Congress requires auditing of Medicare managed care plans. Why not Medicaid? Would this be something you would support?

Answer: Medicare and Medicaid program integrity is of the utmost importance to this Administration, including the oversight of managed care plans participating in these programs. I support efforts, like auditing, to maintain the integrity of these programs and ensure that the plans we do business with are in full compliance with Federal law, regulations, and contracts. Both Medicare and Medicaid participating managed care plans have their payment rates reviewed by the Centers for Medicare & Medicaid Services (CMS). The Affordable Care Act also requires States to provide CMS with Medicaid managed care data, which should further enable us to assess and improve the quality of data submissions we receive in support of managed care rates.

In addition to rate reviews, the Payment Error Rate Measurement program (PERM) estimates a national improper payment error rate for Medicaid. PERM error rates are based on review of the fee-for-service, managed care, and eligibility components of Medicaid in the fiscal year (FY) under review. The managed care component of the FY 2010 Medicaid program payment error rate was 1.0 percent.

5. Given that the Supreme Court will be looking at this law in the coming months or years, we, as a Congress, have to prepare for the possibility that a portion of PPACA might be invalidated, while other parts remain. If the individual mandate were set aside and the remaining portions of the bill were left intact, what would be the impact in the total number of uninsured and, assuming that number would grow, would the Administration seek to find a new way to cover these folks through Medicaid?

Answer: We are continuing to focus on implementing the entire Affordable Care Act, which CBO has estimated will expand affordable health insurance coverage to approximately 34 million uninsured Americans. In 2014, the Administration will implement the Affordable Care Act and help increase the number of insured Americans by assisting States in setting up their Exchanges, making premiums more affordable by holding insurance companies accountable and providing tax credits and reductions in cost-sharing to individuals between 133 and 400 percent

of the Federal Poverty Level (FPL), and expanding Medicaid eligibility to individuals under age 65 with incomes up to 133 percent of the Federal Poverty Level.

6. Secretary Sebelius, as you know, PPACA fines all employers up to $2,000 per employee for not offering qualified health insurance coverage. However, the bill explicitly exempts employers from having to pay the fine for any employee who goes on Medicaid. As a former governor and former insurance commissioner, are you concerned that such a provision could create a crowd out effect of the private insurance market? Does your Department intend to issue information to states on the risk and potential magnitude of such a crowd out effect?

Answer: The Affordable Care Act extends Medicaid eligibility to individuals with incomes up to 133 percent of the Federal poverty level and shields States from bearing the additional cost by increasing Federal matching payments (to 100 percent for the first three calendar years, phasing down to 90 percent for all new adult populations in 2020 and beyond). The Affordable Care Act also imposes a penalty on certain employers with 50 or more full-time equivalent employees that fail to offer health coverage to their full-time employees (and their dependents) if one or more of the employer's full-time employees receives a premium tax credit for coverage acquired on the exchange. The penalty is $2,000 per full-time employee, excluding the first 30 employees.

There is little evidence that crowd-out will occur in the private insurance market as a result of the Medicaid coverage expansion. Many of the individuals who will be newly eligible for Medicaid as a result of the Affordable Care Act previously were uninsured. Evidence from States supports this. In States that have raised Medicaid income eligibility limits to levels similar to those under the Affordable Care Act, the shares of low-income residents who have private coverage are virtually identical to the shares in States that have not expanded Medicaid coverage. For example, one study showed that few adult Medicaid enrollees in Ohio voluntarily dropped private coverage (this study can be found on the CMS website at: https://www.cms.hhs.gov/MMRR/Downloads/MMRR001_01_A01.pdf).

7. Secretary Sebelius, in your letter to governors on February 3, 2011, you note, that you "continue to review what authority, if any, [you] have to waive the maintenance of effort under current law," have you completed a review of your authority? If you need additional authority to assist states, what authority do you need and how would you use it to ensure states have the flexibility they need to change their existing Medicaid programs to decrease state costs?

Answer: As a former Governor, I know the difficult budget pressures facing States. The Administration has a strong track record on our partnership with States during difficult economic times. Working with Congress, we increased Federal support for Medicaid, providing increased financial support to States as they faced increased enrollment at a time when State budgets resources were in decline. As a result, in 2009, even though Medicaid enrollment rose because of the recession, State spending in Medicaid declined by ten percent.

There are a number of steps States can take to reduce costs and squeeze waste, fraud and abuse from their programs. On February 3, 2011, I sent a letter to all Governors laying out a broad

array of options already available to them reduce their spending and balance their budgets, as well as new ideas that can be accomplished through existing options or waivers. States have many choices they can make including limits on some benefits, changes in cost sharing, and greater use of managed care. A copy of the letter can be found at: http://www.hhs.gov/news/press/2011pres/01/20110203c.html.

Medicaid cost issues largely reflect the cost issues facing our health care system as a whole. Like other payers, States can save considerable dollars by focusing on improving the safety and quality of care. Efforts to reduce and eliminate unnecessary hospital readmissions are a great example.

On February 25, 2011, CMS also sent a letter to State Medicaid Directors clarifying situations in which the maintenance of effort provision does not apply. (Please visit the CMS web site for a copy of the letter to States: http://www.cms.gov/smdl/downloads/SMD11001.pdf .) CMS intends to continue to work with Governors on further exploring existing flexibility and options to improve Medicaid's performance. Earlier this year, CMS created the Medicaid State Technical Advisory Teams (M-STAT) that are responsible for working directly with States to address steps they can take to improve efficiency in their programs and develop effective cost containment strategies.

We continue to work closely with States on innovative approaches to improve the quality and efficiency of care provided to high cost beneficiaries, such as those eligible for both Medicare and Medicaid.

8. Secretary Sebelius, does the Department have a list available of which States currently have Medicaid waiver application pending?

Answer: Yes, a list of pending and approved waivers is readily available to the public on the CMS website at: http://www.cms.gov/apps/files/Section1115%20Demos-040111.pdf (please note that this is a temporary link, and the document will ultimately be placed on our Waiver overview page at: http://www.cms.gov/MedicaidStWaivProgDemoPGI/). We will continue to update this chart on a regular basis.

9. Medicaid patients are heavier users of hospital emergency rooms for routine medical care than private policyholders and even the uninsured. If Medicaid is going to expand by another 16 to 20 million people, do you/does the Department have any evidence that the current patterns of Medicaid patients' use of hospital emergency rooms for routine care will decline?

Answer Ensuring that Medicaid recipients have regular access to care is of great importance to both States and CMS. Cutting down on the inappropriate use of hospital emergency departments is important to both the quality of care for all patients and for the fiscal health of the Medicaid program. As we move to expand eligibility in the Medicaid program as required by the Affordable Care Act, we are also implementing a number of Affordable Care Act and policy updates which will help provide a regular source of care for Medicaid patients. In particular, CMS published a proposed regulation on May 6, 2011, related to beneficiary access to care and

we are working on implementing section 1202 of the Health Care and Education Reconciliation Act, which will increase payment for primary care services delivered to Medicaid recipients and help promote better access to non-emergency care.

10. Secretary Sebelius, Currently, CMS has no time standard for answering questions from states. Have you considered implementing an expedited process for the Department, specifically CMS, to answer state inquiries and requests?

Answer: CMS appreciates the importance of the Medicaid State-Federal partnership and works hard to ensure that we are responsive to State needs. While there are statutory standards which govern timelines for certain requests from States, such as State plan amendment requests, CMS has gone a step further to ensure that States receive timely and thorough information. Earlier this year, CMS developed the Medicaid State Technical Advisory Teams (M-STAT), which are charged with working directly with States on their varying questions and requests. To date, M-STAT is working with 22 States on varying requests. At a time of economic challenge for the States, CMS is committed to offering expedient technical assistance to States so that they can make improvements to their Medicaid programs that are beneficial to both Medicaid recipients and their State budgets.

The Honorable Bill Cassidy

1. Madam Secretary, given the upcoming HHS Action Plan on Viral Hepatitis under the Secretary and Assistant Secretary for Health's leadership, how will the Secretary prioritize resources to ensure that when the plan comes out, the federal government takes the needed steps to curtail the escalating costs associated with the viral hepatitis epidemics and their resultant costly outcomes such as liver cancer and end-stage liver disease?

Answer: : On May 12, 2011, HHS issued, "Combating the Hidden Epidemic: U.S. Department of Health and Human Services Action Plan for the Prevention and Treatment of Viral Hepatitis," which outlines actions based on scientific evidence and extensive real-world experience that will serve as a roadmap for reaching the Healthy People 2020 objectives.. HHS is committed to ensuring that new cases of viral hepatitis are prevented and that persons who are already infected are tested; informed about their infection; and provided with counseling, care, and treatment. To achieve these goals, they will focus in six critical areas:

1. Educating Providers and Communities to Reduce Health Disparities;
2. Improving Testing, Care, and Treatment to Prevent Liver Disease and Cancer;
3. Strengthening Surveillance to Detect Viral Hepatitis Transmission and Disease;
4. Eliminating Transmission of Vaccine-Preventable Viral Hepatitis;
5. Reducing Viral Hepatitis Cases Caused by Drug-Use Behaviors; and
6. Protecting Patients and Workers from Health-Care Associated Viral Hepatitis.

By 2020 and in line with the goals of Healthy People 2020, full implementation of the Viral Hepatitis Action Plan could result in:

- An increase in the proportion of persons who are aware of their hepatitis B virus (HBV) infection, from 33 percent to 66 percent;
- An increase in the proportion of persons who are aware of their hepatitis C virus (HCV) infection from 45 percent to 66 percent;
- A 25 percent reduction in the number of new cases of HCV infection; and
- Elimination of mother-to-child transmission of HBV.

A copy of the report is available on the HHS website at http://www.hhs.gov/ash/initiatives/hepatitis/actionplan_viralhepatitis2011.pdf.

The Continuing Resolution providing for FY11 appropriations recently passed by Congress does not specify hepatitis spending. The operating plans for the Department's appropriations, which show the allocation of funds across agency programs, are available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. Within these existing resources, the Department hopes to expand and strengthen surveillance capacity, develop and execute viral hepatitis awareness and training programs for public health and clinical care professionals, and promote viral hepatitis screening and care referral.

The Department's preexisting efforts by the Centers for Disease Control and Prevention (CDC) to address hepatitis prevention and treatment are in alignment with the framework in the Action Plan. As you know, chronic viral hepatitis is a major cause of liver cancer and chronic liver

disease in the U.S. Effective care and treatment can delay or halt disease progression; therefore, identifying those who are infected and referring them to appropriate care are the highest priority actions for HHS and CDC in addressing the illness and death associated with chronic viral hepatitis.

CDC has taken a number of steps to insure that infected persons are aware of their status and referred to care:

- Support for Adult Viral Hepatitis Coordinators in 49 states and several large cities who provide leadership in the integration of viral hepatitis prevention services such as screening and counseling into existing public health programs
- Funding for the development of professional education tools to help primary care providers understand who should be screened and vaccinated
- Demonstration project that is developing best practices for outreach to and case management of HBV-infected Asian-Americans by community based organizations
- Partnership with industry to expand access to testing by supporting development of new testing technologies and strategies, such as point of care tests for HCV
- Laboratory evaluation for specificity and sensitivity of three rapid HCV tests
- Field testing rapid HCV tests to evaluate their use in multiple settings (e.g., HIV testing sites and drug treatment sites)

We look forward to working with Congress to reach the goals laid out in the Action Plan.

2. Given the under-investment in viral hepatitis diseases, has the Secretary considered using additional resources to support viral hepatitis testing and screening efforts among at-risk groups as outlined in the CDC's Division of Viral Hepatitis professional justification?

Answer: The President's FY 2012 budget request includes an increase of $5 million for viral hepatitis. Funds will expand and strengthen surveillance capacity, develop and execute viral hepatitis awareness and training programs for public health, clinical care professionals to implement and scale-up viral hepatitis screening and care referral.

3. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to establish a transition adjustor in the new bundled payment system in a manner that does not take money out of the system. However, I understand from dialysis facilities in my district that the number of facilities that moved immediately into the new prospective payment system (PPS) may be far greater than the Agency estimated in its Final Rule, which will result in a significant payment cut. Given the vulnerability of this patient population, it is critical that CMS properly calculate the transition adjustor using the actual number of facilities that will be paid under the new PPS rather than transitioning into the system over time. Can you explain why CMS has not yet calculated the transition adjustor using the actual number of facilities that moved into the bundle earlier this year and when the Agency plans to correct the adjustor?

Answer: On April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule revising the end-stage renal disease (ESRD) transition budget-neutrality adjustment to reflect the actual election decisions of ESRD facilities to receive 100 percent payment under the ESRD prospective payment system (PPS). This revision will be applied prospectively and results in a zero percent adjustment rather than a decrease in payments of 3.1 percent for renal dialysis services furnished April 1, 2011 through December 31, 2011.

It is important to note that CMS is often statutorily required to ensure that aggregate payments (with the exception of any applicable inflation update) are the same as those under the previous payment system when adopting a new payment system under Medicare. In this case, we were required to ensure that payments under the new ESRD PPS were, in aggregate, 98 percent of the total payments made under the previous basic case-adjusted composite payment system, and that estimated payments under ESRD PPS, including payments under the transition, are equal to what the estimated payments would have been without the transition. Based on the best available data we had at the time, we applied a transition budget neutrality adjustment factor of negative 3.1 percent to ESRD payments in the calendar year 2011 ESRD PPS final rule to meet this requirement. However, as indicated above, we have modified that adjustment based on actual data. The revised adjustment will be applied prospectively and results in a zero percent adjustment rather than a 3.1 percent reduction to payments for renal dialysis services furnished April 1, 2011 through December 31, 2011.

4. I would like you to comment on the Department's efforts at turning successful demonstration projects into meaningful, long-term programs. Specifically, I was encouraged to learn of the positive results of the recently concluded End Stage Renal Disease (ESRD) Disease Management demonstration project in which providers were able to improve health outcomes and lower the overall cost of care for one of Medicare's sickest and most expensive patient populations. Why is the Department not exploring ways to expand on this successful program to most, if not all, of the 400,000 Americans who are on dialysis?

Answer: The Centers for Medicare & Medicaid Services (CMS) is constantly looking at ways to improve the Medicare program and the quality of care furnished to Medicare beneficiaries. The ESRD Disease Management Demonstration allowed Medicare Advantage (MA) organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specialized service areas, whereas before there was no such option. The demonstration worked, in part, by withholding 5 percent of the MA rate, which could be earned on the basis of performance attainment and/or improvement during each year of the demonstration.

While we are continuously working to improve the quality of services for all beneficiaries, the ESRD Quality Incentive Program (QIP) is uniquely designed to promote high-quality dialysis services for beneficiaries with ESRD. The program links Medicare payments directly to dialysis facility performance on quality measures, much like the ESRD Disease Management Demonstration. More specifically, under the QIP, individual dialysis facilities will be held accountable to performance standards and receive a payment adjustment based on the extent to which each facility fails to meet these standards.

The Honorable Ed Whitfield

1. CDC is budgeted to spend $186,226,000 on tobacco prevention and control. About $79 million of that funding comes from PPACA. A main strategy being proposed by the CDC to reduce tobacco use are is to increase the excise tax on cigarettes to reduce initiation and use of tobacco. Have any of these funds been used or will any of these funds be used to lobby States, directly or indirectly, to raise the sales tax on cigarettes?

Answer: HHS is committed to ensuring the proper use of appropriated funds, and to ensuring grantees' compliance with 18 U.S.C. § 1913 as well as the Department's policy regarding lobbying activity of grantees. The Department is committed to fully addressing any violations that occur.

Included within Funding Opportunity Announcements from CDC is an Additional Requirement (AR)-12, "Lobbying Restrictions." AR-12 states CDC's policy prohibiting awardees from using any appropriated federal funds for "any activity designed to influence action in regard to a particular piece of pending legislation." This lobbying prohibition was also included within the Terms and Conditions to which each grantee agreed prior to receiving federal funds. CDC has taken steps to ensure that grantees complying with these requirements:

- The Notice of Grant Awards to all grantees includes written notice of the prohibition on using federal funds for lobbying activity.

- Grantees are reminded of the prohibition on using federal funds for lobbying activity during periodic teleconferences, training sessions, and meetings.

CDC takes seriously its role in ensuring that grantees comply with lobbying restrictions, and we will continue to closely monitor grantees.

2. On June 9th, 2010, I sent you a letter expressing similar concerns that I have yet to receive a response. Would you please also respond to my questions outlined in my correspondence from June 9?" (see below)

Answer: The Director of the CDC, Dr. Thomas Frieden, wrote to you on December 9, 2010. The Communities Putting Prevention to Work (CPPW) program is a $650 million comprehensive prevention and wellness initiation authorized and supported by the American Recovery and Reinvestment Act 2009 (ARRA) and the Affordable Care Act (ACA), to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act, as determined by the Secretary, that deliver specific, measurable, health outcomes that address chronic disease rates. (H.R. 1, page 66, 2009).

CPPW was developed to reduce our nation's enormous health and economic burdens by funding programs to prevent two major chronic disease risk factors—obesity and tobacco. CPPW expands our capacities to build public health policies, strengthens community environments to support health, and establishes successful and sustainable interventions over the long term. The

CPPW program provides for new and expanded community-level chronic disease prevention through policy, systems, and environmental change.

The Centers for Disease Control and Prevention (CDC) grantees are educated on federal laws relating to funding awards, including applicable anti-lobbying provisions. They are informed about funding restrictions and monitored to ensure compliance with such funding restrictions.

CDC informs all grantees about the federal restrictions on lobbying as follows:

- CDC grantees, including CPPW grantees, are educated on all federal laws relating to funding awards including applicable anti-lobbying provisions. Specifically, CDC's Additional Requirement (AR) 12 entitled, "Lobbying Restrictions," is set forth in the Funding Opportunity Announcement (FOA) and lays out in detail the restrictions on applicants' use of HHS funds for lobbying. (FOA CDC-RFA-DP09-012ARRA09. See specifically, SectionVI.2, Administrative and National Policy Requirements, AR 12.)

- Funded communities were explicitly reminded of the prohibition against using federal funds for lobbying activity in an all-hands budget call on Tuesday, February 17, 2010.

- The Notice of Grant Awards sent to communities on March 18, 2010, again included written notice about the prohibition against using federal funds for lobbying activity (see note 16 in the Notice of Grant Awards).

- CDC reiterated the applicable prohibitions against lobbying at the program kick-off meeting in April, including a presentation directing all the communities to the AR 12 for guidance.

Reporting of ARRA Progress

The CPPW program has a robust plan for performance monitoring in order to ensure that federal funds are used effectively and appropriately. The plan is designed to ensure CDC staff is positioned to identify early warning signs that a program is falling off track or using federal funds for unauthorized and inappropriate activities. An electronic performance monitoring system provides a central repository for collecting information from a number of program monitoring sources:

- Budget Reviews and Reviews of Community Action Plans and State/Territory Work Plans.

- Project Officer Monitoring System that includes instructions derived from a number of sources, including a tracking sheet of outcome objectives and key milestone activities that are completed quarterly by each Project Officer. This includes monthly conference calls and project management reports, annual site visit reports completed by Project Officers and submitted for the record at CDC's Procurement and Grants Office (PGO) upon return from each site visit, substantive correspondence providing support, and

reports submitted to PGO as part of the record, such as budgets, personnel, community action plans, and other documentation.

In addition to the robust performance monitoring described above, PGO provides additional and specific budgetary oversight to ensure the appropriate use of federal funds. PGO staff will participate in annual site visits to all funded communities.

With respect to reporting, recipients of ARRA awards are required to submit quarterly reports to the Recovery Accountability and Transparency Board through the FederalReporting.gov system. These reports must contain an estimate of the number of jobs funded by the project or activity during the quarter, as prescribed in Section 5 of the Office of Management and Budget (OMB) guidance M-09-21, as amended by OMB guidance M-10-08.

Recipients must use a specific formula provided by OMB to calculate the number of jobs funded using ARRA funds. Quarterly reports are available at www.recovery.gov, the Recovery Accountability and Transparency Board's website.

To access reports on community activity visit the url below and type in the name of the recipient: www.recovery.gov/Pages/TextViewProjSummary.aspx?data=recipientAwardsList&RenderData=ALL&State=ALL&Agency=75&Amount=ALL&AwardType=CGL

For your convenience, the list of CPPW recipients is available at: www.cdc.gov/chronicdisease/recovery/PDF/HHS_CPPW CommunityFactSheet.pdf

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Congress of the United States
House of Representatives
Washington, DC 20515–1701

June 9th, 2010

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

I am writing regarding a provision that was included in the stimulus bill that could potentially jeopardize jobs. It is my understanding that federal grant dollars are being used by HHS to fund the passage of new state and local laws to raise taxes, restrict the sale of certain products, and interfere with competition among manufacturers. I am concerned that the funding of such policy proposal efforts with federal stimulus dollars does not create private sector jobs, it jeopardizes them.

Specifically, in February and March, the CDC's new Communities Putting Prevention To Work (CPPW) initiative awarded just under $500 million in competitive and non-competitive grants to states, cities, and tribes. It is my understanding that many of the grant awards require the grantee to use a portion of the awards to advocate for or support the passage of new laws.

For example, I've been told that the CDC required that all 58 states and territories receiving non-competitive "base" awards pursue a tax increase on tobacco products. Among the competitive awards are grants to "support a policy proposal to increase tobacco price;" "implement menu labeling;" "set policies and create environments that reduce consumption of sugar-sweetened beverages and overly salted foods;" "eliminate … price discounts;" "reduce sodium consumption… through labeling initiatives and restaurant standards;" and "limit tobacco access through zoning/license restrictions." The CDC's instructions to grantees even suggest that cities use federal funds to enact "zoning policies" to "reduce the density of fast food establishments."

We all want to educate individuals about healthy lifestyle choices and find ways to encourage healthy decisions. However, I believe that using federal grants to fund the passage of new laws and regulations at the state and local level to force the desired results by limiting consumer choice or by making the choices individuals make more expensive, is not the right way to achieve our mutual goals.

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On the job creation issue, it is my understanding that all CPPW grantees were required to submit their first quarterly reports to HHS by April 10, 2010 that contained "a detailed list of all projects or activities for which Recovery Act funds under this award were obligated and expended, including" ... "an estimate of the number of jobs created and the number of jobs retained by the project or activity...".

I would appreciate your providing me a full and complete description of the CDC's policy on grantees' lobbying state and local governments with federal grant dollars, and a comprehensive description of how the CDC plans to ensure grantee compliance with this policy. Please also provide for me copies of the quarterly reports each grantee submitted by April 10, 2010 as well as a cumulative total of the "number of jobs created." Out of that total, please specify how many jobs created are public sector jobs and how many are private sector jobs.

Thank you for your attention to this matter and your prompt reply to my inquires.

Sincerely,

Ed Whitfield

Ed Whitfield
Member of Congress

The Honorable Robert E. Latta

1. In light of the deadline passing for my, and my colleagues', questions regarding the use of telemedicine or telehealth videoconferencing methods to dispense mifespristone to patients without having a doctor present, I am requesting answers to the questions asked in the following letter, dated February 3, 2011.

Answer: In my response letter dated May 26, 2011, I explained that the use of telehealth technologies allows the Department to better meet the needs of underserved populations by delivering quality health care, education, and health information services through videoconferencing, the internet, and other means. Below, please find responses to the specific questions raised in the letter:

a) **In total, how much federal funding has been appropriated for telemedicine and what portion of those funds have been used to purchase telemedicine equipment?**

Answer: Within the Department of Health and Human Services, the only targeted funding source for telemedicine is administered by HRSA. This funding is detailed in the following table:

Grant Program Name	Total Appropriated	Telemedicine Equipment
Telehealth Network Grant Program	$6,500,160	$60,446
Telehealth Resource Centers	$2,943,837	$30,000
Licensure Portability Grant Program	$350,000	$75,000
Congressionally Mandated Projects	$25,754,850	$13,402,310
Total	**$35,548,847**	**$13,567,756**

b) **Have any additional funds other than those described in question (a) been used to fund telemedicine? (E.g. have funds that were not specifically designated for telemedicine been used to support telemedicine.)**

Answer: In addition to the funding described above, the Indian Health Service uses telemedicine for acute and chronic care such as: diabetes care, cardiovascular care, and mental health care.

c) **Has the Planned Parenthood Federation of America (PPFA), its affiliates, or clinics received any telemedicine funding? If so, please provide a list of PPFA affiliates and clinics that received funds for telemedicine and indicate the amount of funding provided to each. (Include both primary grantees and subgrantees.)**

Answer: There are two HRSA grantees whose networks include Planned Parenthood. These funds were used to support purchases related to electronic health records (EHR) and a portion of an FTE. Information regarding both of these grants is provided below.

- The Association for Utah Community Health (AUCH) was the recipient of a congressionally mandated project (CMP) award focusing on health information technology and EHR implementation in 2008 and 2009. The sponsors of these CMP for both grants were Representative Jim Matheson and Senators Bob Bennett and Orrin Hatch. Members of the AUCH include 11 federally qualified health centers, Planned Parenthood of Utah, the Indian Walk-In Center, Utah Telehealth Network, Northwest Regional Telehealth Network, Retina Associates of Utah, Wire One Technology, Inc., and Utah Imaging, LLC. AUCH distributed $72,270 to Planned Parenthood of Utah for the purchase of EHR equipment and software.

- The University of Utah is the recipient of a Telehealth Network Grant Program (TNGP) grant funded through HRSA. The members of the network include the Association for Utah Community Health (AUCH); Community Health Centers, Inc.; Utah Navajo Health System; and the following four University of Utah organizations: Department of Internal Medicine, Department of Biomedical Informatics, Stansbury Health Center and University of Utah Stroke Center.

  Through the TNGP grant to the University of Utah, AUCH utilizes grant funds to support a 0.2 FTE to serve as an AUCH Telehealth Coordinator and Project Coordinator. This individual facilitates the implementation of clinical services, including development of new clinical protocols and educational plans. As indicated above, Planned Parenthood is one of the members of AUCH.

d) Have any other facilities that perform abortions received telemedicine funding? If so, please provide a list of the facilities and indicate the amount of funding provided to each. (Include both primary grantees and subgrantees.)

Answer: Federal funding cannot be used for abortion, except in cases of rape, incest or endangerment of the woman's life. All HRSA grantees are required to certify that they are in compliance with all federal laws, executive orders, regulations, and policies, and that certification is documented in each grant application as part of Standard Form 424B. A copy of the form is attached. Grantees, in signing the certification, confirm that they are within the confines of applicable law. HRSA tracks the appropriate use of federal funds related to grant program activities.

e) Has the Department of Health and Human Services taken any measures to ensure that federal funding for the telemedicine and equipment is not used to facilitate telemed abortions? If so, please provide a copy of any memos or guidance issued to safeguard against taxpayer funding for telemed abortion.

Answer: Federal funding cannot be used for abortion, except in cases of rape, incest or endangerment of the woman's life. As stated above, all HRSA grantees are required to certify that they are in compliance with all federal laws, executive orders, regulations, and policies, and that certification is documented in each grant application as part of Standard Form 424B.

Congress of the United States
Washington, DC 20515

February 3, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius,

It has come to our attention that Planned Parenthood clinics in Iowa are using telemedicine or telehealth videoconferencing methods to dispense mifepristone, the abortion drug commonly known as RU-486, to patients without having a doctor present. We are concerned that this practice of "telemed abortions" may have received taxpayer funding and we are concerned that similar programs may receive taxpayer funding in the future, despite federal laws that prohibit taxpayer funding for abortion. If federal dollars are used for telemed abortions, it would make American taxpayers complicit in underwriting the destruction of innocent unborn children and supporting organizations that endanger women's lives and health by intentionally circumventing FDA guidelines for dispensing RU-486.

The Food and Drug Administration (FDA) requires that RU-486 "be provided by or under the supervision of a physician who meets the following qualifications: ability to assess the duration of pregnancy; ability to diagnose ectopic pregnancies; ability to provide surgical intervention in cases of incomplete abortion or severe bleeding..." We believe dispensing RU-486 via telemedicine violates FDA protocols and puts women's safety and health at risk.

According to the Associated Press, the manufacturer of RU-486, Danco Laboratories, says "it [RU-486] is effective about 95 percent of the time, with surgical procedures needed in most of the other cases to end the pregnancy or stop heavy bleeding."[1] Planned Parenthood, quoting the American College of Obstetricians and Gynecologists acknowledges, "about 92 percent of women will complete their [RU-486 induced] abortion without the need for a vacuum aspiration,"[2] meaning nearly one in ten women who take RU-486 will require surgical intervention by a doctor to complete the abortion. A doctor dispensing RU-486 over the internet from a location hundreds or even thousands of miles away is clearly unable to provide surgical intervention in cases of severe bleeding.

RU-486 is a dangerous drug that has been associated with at least 11 deaths and thousands of cases of excessive bleeding and infection. Evading FDA guidelines by dispensing RU-486

[1] http://abcnews.go.com/US/wireStory?id=11730510&nclick_check=1
[2] http://www.plannedparenthood.org/files/PPFA/mife_RU-07.pdf

through telemedicine has the potential to increase complications and fatalities associated with its use. We cannot allow taxpayer dollars to be used to support telemed abortions.

Most recently, in Fiscal Year 2010, Congress provided the Department of Health and Human Services' Health Resources and Services Administration (HRSA) with $11.6 million for its telehealth program. While telemedicine may be a positive means of providing certain health services, abortion is not healthcare, and dispensing RU-486 without a doctor present is both risky to the mother and deadly to the unborn child. U.S. taxpayers should not be forced to underwrite abortions, nor should Americans' tax dollars be used to circumvent FDA guidelines regarding RU-486.

We are particularly concerned that affiliates of the Planned Parenthood Federation of America (PPFA), the largest abortion provider in the United States, may be receiving federal funding and using federally funded equipment to facilitate telemed abortions — meaning federal taxpayers are funding abortions. It has come to our attention that:

- Planned Parenthood of Utah is listed as a grant recipient in the HRSA 2007-2008 Office for the Advancement of Telehealth Grantee Directory;
- Planned Parenthood of the Heartland in Iowa is known to provide telemedicine RU-486 abortions;
- Planned Parenthood clinics at 10 locations in Wisconsin received a federal grant to pay for telemedicine video phones which cost $15,000 each[3];
- PPFA Vice President Dr. Vanessa Cullins said "There are many [PPFA] affiliates that are carefully considering [telemed abortion][4];" and
- A June 2009 report by Tides and the California Endowment wrote of the 'unprecedented opportunity' due to 'new funding for health-information technology at the federal level,' listing nine California Planned Parenthoods as 'community clinics' for which telemed grants might be available."[5]

In light of these concerns, we respectfully request a response to the following questions no later than March 2, 2011:

1. In total, how much federal funding has been appropriated for telemedicine and what portion of those funds have been used to purchase telemedicine equipment?
2. Have any additional funds other than those described in question (1) been used to fund telemedicine? (E.g. have funds that were not specifically designated for telemedicine been used to support telemedicine.)
3. Has the Planned Parenthood Federation of America (PPFA), its affiliates, or clinics received any telemedicine funding? If so, please provide a list of PPFA affiliates and clinics that received funds for telemedicine and indicate the amount of funding provided to each. (Include both primary grantees and subgrantees.)
4. Have any other facilities that perform abortions received telemedicine funding? If so, please provide a list of the facilities and indicate the amount of funding provided to each. (Include both primary grantees and subgrantees.)

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[3] http://www.bizjournals.com/milwaukee/stories/2010/11/15/story12.html?s=print
[4] http://abcnews.go.com/US/wireStory?id=[illegible]
[5] http://www.[illegible]

The Honorable Edolphus Towns

1. Secretary Sebelius, earlier this year you said the Prevention and Public Health Fund is "going to build on the prevention work already under way to help make sure that we are working effectively across the federal government, as well as with private groups and state and local governments to help Americans live longer, healthier lives."

Currently, there is a public-private partnership where results-based performance drives incentives called the National Diabetes Prevention Program. It has been getting outstanding results and insurers are paying for prevention. By the end of this year, the NDPP will be operating at 116 sites in 24 states. However, with 79 million people with pre-diabetes, the scope of the need is immense and the federal government needs to be a partner in this effort.

Given that the NDPP appears to be an exact match for the stated goals of the Prevention and Public Health Fund, can we count on your support for it going forward?

Answer: As a leading cause of death and disability in the United States, diabetes is an important public health priority. The National Diabetes Prevention Program (NDPP) is an effective program to prevent or delay the onset of type 2 diabetes, which accounts for 90-95% of all diabetes cases. With funding from CDC and/or the United Health Group, the NDPP is currently offered in over 150 sites in select communities across 23 states and the District of Columbia.

CDC is working to ensure quality and integrity of the NDPP through the planning and development of a Diabetes Prevention Recognition Program (DPRP). Implementation of the DPRP will help assure the highest level of fidelity to the evidence-based lifestyle interventions, lead to reimbursement by insurers for the lifestyle intervention and allow CDC to develop a registry of programs that will provide information to people at high risk of type 2 diabetes, their health care providers, and health payers on the performance of local, community-based diabetes prevention programs. As the recognition program is implemented, more organizations will become involved in delivering the program intervention.

The FY 2012 President's Budget offers two potential opportunities to continue and expand the NDPP. The Coordinated Chronic Disease Prevention and Health Promotion (CCDPP) grant program includes a competitive component for states to establish core activities that could include the prevention of diabetes. Additionally, under the Community Transformation Grant program funded grantees could choose to implement the Diabetes Prevention Program as part of their plan to promote healthy living and reduce disparities.

2. Additionally, PPACA included several provisions intended to improve diabetes care: the creation of a National Diabetes Report Card, training for states on accurate reporting of vital statistics, including death certificates for chronic diseases like diabetes, and a study by the Institute of Medicine on the appropriate level of diabetes medical education.

Where is the Department on the implementation of these provisions?

Answer: CDC is responsible for development of the Diabetes Report Card in response to the provisions of the Patient Protection and Affordability Care Act, Section 10407 of Public Law 111-148. This section directs the Secretary, in collaboration with the Director of CDC, to biennially prepare a national diabetes report card which aggregates data about health outcomes related to individuals diagnosed with diabetes and pre-diabetes. Currently, CDC is reviewing its established data sources to prioritize and select information that best represents national and state diabetes data regarding prevalence, preventative care practices and the quality of care, risk factors, health outcomes and national progress in meeting Healthy People goals. CDC anticipates release of the National Diabetes Report Card during FY 2012.

CDC's National Center for Health Statistics (NCHS) serves as the lead for vital statistics for HHS. NCHS in collaboration with the National Association for Public Health Statistics and Information Systems (NAPHSIS) has developed an internet training module for physicians completing the death certificate – the training is for all causes of death. The training was made available to states at the annual NAPHSIS meeting in June 2011.

3. I have long been a vocal advocate for investing our prevention dollars wisely. I feel that one of these areas is in the prevention and treatment of Viral Hepatitis. As you know, around two-thirds of those living with hepatitis C are estimated to be baby boomers, and approximately 75 percent do not know it. A major driver of costs will be from 2-3 million baby boomers aging into Medicare, resulting in a six-fold increase in hepatitis C related Medicare costs from $5 billion to $30 billion. Treating earlier stages of the disease is significantly more cost efficient and effective than allowing the disease to progress to end-stage liver disease or liver transplants.

Given the upcoming HHS Action Plan on Viral Hepatitis under the Secretary and Assistant Secretary for Health's leadership, how will the Secretary prioritize resources to ensure that when the plan comes out, the federal government takes critical steps to curtail the escalating costs associated with the viral hepatitis epidemics and their resultant costly outcomes such as liver cancer and end-stage liver disease?

Answer: On May 12, 2011, HHS issued "Combating the Hidden Epidemic: U.S. Department of Health and Human Services Action Plan for the Prevention and Treatment of Viral Hepatitis," which outlines actions based on scientific evidence and extensive real-world experience that will serve as a roadmap for reaching the Healthy People 2020 objectives. HHS is committed to ensuring that new cases of viral hepatitis are prevented and that persons who are already infected are tested; informed about their infection; and provided with counseling, care, and treatment. To achieve these goals, they will focus in six critical areas:

1. Educating Providers and Communities to Reduce Health Disparities;
2. Improving Testing, Care, and Treatment to Prevent Liver Disease and Cancer;
3. Strengthening Surveillance to Detect Viral Hepatitis Transmission and Disease;
4. Eliminating Transmission of Vaccine-Preventable Viral Hepatitis;
5. Reducing Viral Hepatitis Cases Caused by Drug-Use Behaviors; and
6. Protecting Patients and Workers from Health-Care Associated Viral Hepatitis.

By 2020 and in line with the goals of Healthy People 2020, full implementation of the Viral Hepatitis Action Plan could result in:

- An increase in the proportion of persons who are aware of their hepatitis B virus (HBV) infection, from 33 percent to 66 percent;
- An increase in the proportion of persons who are aware of their hepatitis C virus (HCV) infection from 45 percent to 66 percent;
- A 25 percent reduction in the number of new cases of HCV infection; and
- Elimination of mother-to-child transmission of HBV.

A copy of the report is available on the HHS website at http://www.hhs.gov/ash/initiatives/hepatitis/actionplan_viralhepatitis2011.pdf.

The Continuing Resolution providing for FY11 appropriations recently passed by Congress does not specify hepatitis spending. The operating plans for the Department's appropriations, which shows the allocation of funds across agency programs, are available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. Within these existing resources, the Department hopes to expand and strengthen surveillance capacity, develop and execute viral hepatitis awareness and training programs for public health and clinical care professionals, and promote viral hepatitis screening and care referral.

The Department's preexisting efforts by the Centers for Disease Control and Prevention (CDC) to address hepatitis prevention and treatment are in alignment with the framework in the Action Plan. As you know, chronic viral hepatitis is a major cause of liver cancer and chronic liver disease in the U.S. Effective care and treatment can delay or halt disease progression; therefore, identifying those who are infected and referring them to appropriate care are the highest priority actions for HHS and CDC in addressing the illness and death associated with chronic viral hepatitis.

CDC has taken a number of steps to insure that infected persons are aware of their status and referred to care:

- Support for Adult Viral Hepatitis Coordinators in 49 states and several large cities who provide leadership in the integration of viral hepatitis prevention services such as screening and counseling into existing public health programs
- Funding for the development of professional education tools to help primary care providers understand who should be screened and vaccinated
- Demonstration project that is developing best practices for outreach to and case management of HBV-infected Asian-Americans by community based organizations
- Partnership with industry to expand access to testing by supporting development of new testing technologies and strategies, such as point of care tests for HCV
- Laboratory evaluation for specificity and sensitivity of three rapid HCV tests
- Field testing rapid HCV tests to evaluate their use in multiple settings (e.g., HIV testing sites and drug treatment sites)

We look forward to working with Congress to reach the goals laid out in the Action Plan.

4. Given the fact that 65-75% of people infected have not been diagnosed, has the Secretary considered using mandatory funding similar to funds that went to HIV and other chronic diseases from PPACA's Prevention and Public Health Fund, to support much-needed viral hepatitis testing and screening efforts among at-risk groups?

Answer: HHS remains committed to addressing viral Hepatitis and continues to supports a broad range of programs supporting surveillance, screening, education, vaccination, and research on this condition. In May of this year, HHS released an action plan for the prevention, care, and treatment of viral hepatitis which outlines specific goals and action steps based on scientific evidence. The plan specifically encourages coordination and collaboration within HHS and across other Federal agencies. The FY 2012 President's Budget in particular requests an increase within the Centers for Disease Control and Prevention (CDC) to support viral hepatitis activities.

The Prevention and Public Health Fund specifically provides a significant investment in prevention, wellness, and public health to improve the health of the Nation and help restrain health care costs. Each year funds are allocated to create a strong portfolio of investments in areas such as community prevention, public health infrastructure, and health care surveillance in order to achieve the greatest health impact. Currently funded State and local investments in public health research and public health infrastructure, for example, already have the potential to enhance community efforts. In addition, the CDC Section 317 Immunization Program, which receives Prevention Fund dollars, allows States to purchase adult hepatitis B vaccines and provides flexibility in how States target funds within specific risk groups.

5. Since we know that vaccination is cost-effective and that the hepatitis B vaccine is one of the safest and most effective vaccines, how will the Secretary seek to restore funds for the recently discontinued Adult Hepatitis B Vaccination Initiative through the Section 317 Vaccine Program?

Answer: In November 2006, CDC and the Advisory Committee on Immunization Practices recommended universal hepatitis B vaccination in care settings (e.g., STD/HIV prevention and treatment clinics, drug treatment centers, and correctional facilities) where a high proportion of clients are at risk for hepatitis B virus (HBV) infection. The publication of those new guidelines for adult hepatitis B vaccination presented an opportunity to renew the public health commitment to protecting adults at risk for HBV. States were encouraged to consider the use of their Section 317 vaccine funding for the purchase of adult hepatitis B vaccine. To support collaboration among immunization, STD, HIV, and viral hepatitis prevention programs, state hepatitis C and/or hepatitis B coordinators convened and facilitated meetings to develop action plans to define targeted populations, vaccination settings, number of vaccine doses needed, and the responsibilities of the participating public health programs. At the same time, CDC made available a variety of training and educational materials and provided technical assistance to state and local programs interested in adult hepatitis B vaccination.

Under the Section 317 program states have broad decision-making ability as to which ages, high-risk groups, or disease will be targeted with these limited funds. States are in the best position to make the difficult decisions about how to balance their Section 317 resources to meet the needs of the children, adolescents, and adults in their jurisdictions. States still are able to prioritize the purchase of hepatitis B vaccine for adults with their Section 317 funds. CDC's support for such an approach has not changed.

In 2007, CDC began a process of centralizing distribution for public sector vaccine. This change in vaccine management substantially reduced the size of the inventory of vaccines purchased with Section 317 funds, which resulted in significant one-time savings for the Section 317 program. As centralized distribution was fully implemented, CDC directed this one-time savings for the sole purchase of hepatitis B containing vaccines for the Adult Hepatitis B Initiative. It was hoped that the provision of vaccine would foster partnerships among public health programs working to prevent hepatitis B infections, and that these partnerships would sustain an adult hepatitis B effort after the savings were exhausted.

The health insurance reforms of the Affordable Care Act offer opportunities to address the need for increased adult hepatitis B vaccination. Pursuant to these reforms, Medicare, Medicaid, and some private insurance plans have already begun to cover recommended preventive services such as hepatitis B vaccination of at-risk adults; that coverage will continue to grow in the coming years as the reforms are fully implemented. In addition, the Affordable Care Act will reduce the pool of underinsured children who are not eligible to receive Vaccines for Children (VFC) program vaccines. Historically, most of the 317 vaccine purchase funding has been used to purchase pediatric vaccines for this group of children. As the pool of underinsured children decreases, states will be able to shift their focus to providing vaccines to vulnerable adult populations without health insurance, including to high-risk adults for hepatitis B vaccination.

The Honorable Lois Capps

1. Children's hospitals care for children with complex health conditions and are safety net providers who serve a large number of Medicaid and uninsured patients. Children's Hospital Graduate Medical Education supports 55 children's hospitals that train approximately 35 percent of all pediatricians, 43 percent of all pediatric specialists, and many pediatric researchers and physicians who require pediatric training. Yet, the budget proposal would eliminate funding for CHGME. Can you please explain the rationale for this cut?

Answer: While the Fiscal Year 2012 proposed budget required difficult choices, it includes a strong focus on responding to the health care workforce shortage by investing in the training and development of primary care providers. Within the constrained budget environment, the Fiscal Year 2012 proposed budget prioritizes competitive and targeted activities that will support the training of primary care providers, including general pediatricians. Strengthening and growing the primary care workforce is a critical component of reforming the nation's health care system. Increasing access to primary care providers can help prevent disease and illness and help ensure that all Americans – regardless of where they live – have access to high quality care.

Entity	TOTAL	Infrastructure	ELC	EIP	ARRA evaluation (BRFSS)	ARRA Media	CPPW	HIV Lab	HIV Testing	HIV Planning	Quitline	Tobacco Media	National Strategy	Health Care Surveillance	Community Guide	Workforce
ALABAMA STATE DEPT OF PUBLIC HEALTH	$ 4,168,295	$ 200,000	$ 361,795	$ -	$ 749,995	$ -	$ 2,500,000	$ 136,711	$ 145,567	$ -	$ 74,227	$ -	$ -	$ -	$ -	$ -
ALASKA STATE DEPARTMENT OF HLTH-SOC SVCS	$ 555,467	$ 100,000	$ 413,558	$ -	$ -	$ -	$ -	$ 41,909	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ALASKA NATIVE TRIBAL HEALTH CONSORTIUM	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SOUTHEAST ALASKA REG HLTH CONSORTIUM	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AMERICAN SAMOA DEPARTMENT OF HEALTH	$ 109,797	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ 9,797	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ARIZONA STATE DEPARTMENT OF HLTH SRVCS	$ 726,471	$ 289,586	$ 117,120	$ -	$ -	$ -	$ -	$ 90,262	$ 145,567	$ -	$ 83,936	$ -	$ -	$ -	$ -	$ -
COUNTY OF MARICOPA	$ 199,434	$ 199,434	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GILA RIVER INDIAN COMMUNITY	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NAVAJO NATION DIVISION OF HEALTH	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ARKANSAS STATE DEPT OF HEALTH	$ 3,734,438	$ 200,000	$ 442,594	$ -	$ 892,025	$ -	$ 1,800,000	$ 114,182	$ -	$ -	$ 64,867	$ -	$ -	$ 220,770	$ -	$ -
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH	$ 3,737,373	$ 2,060,128	$ 677,043	$ 198,869	$ -	$ -	$ -	$ 415,593	$ 145,567	$ -	$ 240,173	$ -	$ -	$ -	$ -	$ -
County of Santa Clara	$ 3,600,000	$ -	$ -	$ -	$ -	$ -	$ 3,600,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
COUNTY/SAN DIEGO HEALTH / HUMAN SER/AG	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LOS ANGELES COUNTY HEALTH SERVICES DEPT	$ 3,668,485	$ 1,859,950	$ 412,980	$ -	$ -	$ -	$ -	$ 190,581	$ 145,567	$ 1,059,407	$ -	$ -	$ -	$ -	$ -	$ -

SAN FRANCISCO DEPT OF PUBLIC HEALTH	$ 1,204,616	$ -	$ -	$ -	$ -	$ -	$ -	$ 171,081	$ 145,567	$ 887,968	$ -	$ -	$ -	$ -	$ -	$ -
COLORADO STATE DEPT/PUB HLTH & ENVIRONMT	$ 1,065,880	$ 300,000	$ 327,908	$ 295,655	$ -	$ -	$ -	$ 68,390	$ -	$ -	$ 73,927	$ -	$ -	$ -	$ -	$ -
CONNECTICUT STATE DEPT OF PUBLIC HEALTH	$ 886,105	$ 200,000	$ 145,694	$ 247,028	$ -	$ -	$ -	$ 79,714	$ 145,567	$ -	$ 68,102	$ -	$ -	$ -	$ -	$ -
DC DEPARTMENT OF HEALTH	$ 1,438,645	$ 100,000	$ 10,000	$ -	$ -	$ -	$ -	$ 183,595	$ 145,567	$ 946,403	$ 53,080	$ -	$ -	$ -	$ -	$ -
AMERICAN PUBLIC HEALTH ASSOCIATION	$ 750,000	$ 750,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MATERNAL AND	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 100,000	$ -
NATIONAL ASSOCIATION OF CITY/COUNTY HEALTH OFFICIALS	$ 1,250,000	$ 750,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500,000	$ -
PUBLIC HEALTH	$ 1,272,000	$ 750,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 350,000	$ 172,000
DELAWARE STATE DEPT OF HLTH & SOC SRVS	$ 512,906	$ 100,000	$ 307,243	$ -	$ -	$ -	$ -	$ 51,218	$ -	$ -	$ 54,445	$ -	$ -	$ -	$ -	$ -
FEDERATED STATES MICRONESIA	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FLORIDA STATE DEPARTMENT OF HEALTH	$ 4,410,698	$ 2,060,128	$ 423,403	$ -	$ 326,905	$ -	$ -	$ 400,000	$ 145,567	$ 909,315	$ 145,380	$ -	$ -	$ -	$ -	$ -
PINELLAS County Health Dept	$ 4,850,000	$ -	$ -	$ -	$ 500,000	$ -	$ 4,350,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GEORGIA DEPARTMENT OF COMMUNITY HEALTH	$ 2,237,397	$ 399,836	$ 223,117	$ 309,358	$ 109,533	$ -	$ -	$ 35,431	$ 145,567	$ 913,982	$ 100,573	$ -	$ -	$ -	$ -	$ -
DeKalb County Board of Public Health	$ 2,661,000	$ -	$ -	$ -	$ 61,000	$ -	$ 2,350,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 250,000

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLGISTS	**$ 335,000**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 335,000
American Cancer Society	**$ 499,582**	$ -			$ -	$ -						$ -	$ -	$ -	$ 499,582	$ -	$ -
GUAM DEPARTMENT OF PUBLIC HEALTH-SOC SVC	**$ 175,000**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ 25,000	$ -	$ -	$ 50,000	$ -	$ -	$ -	$ -	$ -
HAWAII STATE DEPARTMENT OF HEALTH	**$ 1,381,990**	$ 1,100,000	$ 240,142	$ -	$ -	$ -	$ -	$ 41,848	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PACIFIC ISLANDS HEALTH OFFICERS ASSN	**$ 1,660,128**	$ 1,660,128	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
IDAHO STATE DEPT OF HEALTH AND WELFARE	**$ 536,667**	$ 200,000	$ 254,056	$ -	$ -	$ -	$ -	$ 24,658	$ -	$ -	$ 57,953	$ -	$ -	$ -	$ -	$ -
ILLINOIS STATE DEPT OF PUBLIC HEALTH	**$ 1,421,142**	$ 400,000	$ 586,815	$ -	$ 99,845	$ -	$ -	$ 72,489	$ 145,567	$ -	$ 116,426	$ -	$ -	$ -	$ -	$ -
CITY OF CHICAGO	**$ 7,226,668**	$ 200,000	$ 136,789	$ -	$ -	$ -	$ 5,800,000	$ 16,941	$ 145,567	$ 927,371	$ -	$ -	$ -	$ -	$ -	$ -
INDIANA STATE DEPARTMENT OF HEALTH	**$ 876,986**	$ 300,000	$ 493,938	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 83,048	$ -	$ -	$ -	$ -	$ -
IOWA STATE DEPT OF PUBLIC HEALTH	**$ 774,481**	$ 200,000	$ 407,337	$ -	$ -	$ -	$ -	$ 101,668	$ -	$ -	$ 65,476	$ -	$ -	$ -	$ -	$ -
KANSAS STATE DEPT OF HLTH AND ENVIRONMNT	**$ 523,981**	$ 200,000	$ 259,936	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 64,045	$ -	$ -	$ -	$ -	$ -
KY CABINET FOR HEALTH AND FAMILY SERVICES	**$ 734,317**	$ 200,000	$ 389,385	$ -	$ -	$ -	$ -	$ 72,899	$ -	$ -	$ 72,033	$ -	$ -	$ -	$ -	$ -
LOUISIANA STATE DEPT OF HLTH & HOSPITALS	**$ 805,469**	$ 200,000	$ 289,273	$ -	$ -	$ -	$ -	$ 97,517	$ 145,567	$ -	$ 73,112	$ -	$ -	$ -	$ -	$ -

NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES	$ **1,450,000**	$ 1,000,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ 450,000	$ -
MAINE STATE DEPT/HEALTH/HUMAN SERVS	$ **2,145,294**	$ 1,758,786	$ 273,410	$ -	$ -	$ -	$ -	$ 60,000	$ -	$ -	$ 53,098		$ -	$ -	$ -	$ -	$ -
REPUBLIC/MARSHALL ISLAND MNSTRY OF HLTH	$ **100,000**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
MARYLAND STATE DEPT OF HLTH/MTL HYGIENE	$ **2,095,973**	$ 300,000	$ 231,600	$ 230,728	$ -	$ -	$ -	$ 229,857	$ 145,567	$ 878,896	$ 79,325		$ -	$ -	$ -	$ -	$ -
MASSACHUSETTS STATE DEPT OF PUB HEALTH	$ **2,877,117**	$ 1,960,128	$ 598,230	$ -	$ -	$ -	$ -	$ 89,268	$ 145,567	$ -	$ 83,924		$ -	$ -	$ -	$ -	$ -
MICHIGAN STATE DEPT OF COMMUNITY HEALTH	$ **1,025,971**	$ 400,000	$ 243,670	$ -	$ -	$ -	$ -	$ 135,438	$ 145,567	$ -	$ 101,296		$ -	$ -	$ -	$ -	$ -
MINNESOTA STATE DEPT OF HEALTH	$ **2,781,929**	$ 1,960,128	$ 304,209	$ 322,544	$ -	$ -	$ -	$ 117,953	$ -	$ -	$ 77,095		$ -	$ -	$ -	$ -	$ -
MILLE LACS BAND OF OJIBWE INDIANS	$ **99,866**	$99,866	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
MISSISSIPPI STATE DEPARTMENT OF HEALTH	$ **726,892**	$ 199,585	$ 302,720	$ -	$ -	$ -	$ -	$ 79,020	$ 145,567	$ -	$ -		$ -	$ -	$ -	$ -	$ -
MISSOURI STATE DEPT/ HEALTH & SENIOR SRV	$ **789,634**	$ 300,000	$ 263,260	$ -	$ -	$ -	$ -	$ -	$ 145,567	$ -	$ 80,807		$ -	$ -	$ -	$ -	$ -
MONTANA STATE DEPT/PUB HLTH & HUMAN SRVS	$ **412,811**	$ 100,000	$ 312,811	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
MONTANA WYOMING TRIBAL LEADERS COUNCIL	$ **100,000**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -

COMMONWEALTH N MARIANA IS DEPT PUB HLTH	$ 100,000	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
NEBRASKA ST DEPT OF HEALTH & HUMAN SERVS	$ 1,475,479	$ 1,200,000	$ 148,500	$ -	$ -	$ -	$ -	$ 67,735	$ -	$ -	$ 59,244	$ -	$ -	$ -	$ -	$ -	
NEVADA STATE DEPT OF HLTH/HUMAN SVCS	$ 428,745	$ 200,000	$ 90,000	$ -	$ -	$ -	$ -	$ 75,576	$ -	$ -	$ 63,169	$ -	$ -	$ -	$ -	$ -	
Southern Nevada Health District	$ 3,800,000	$ -	$ -	$ -	$ -	$ -	$ 3,800,000	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	
NH STATE DEPT OF HEALTH AND HUMAN SERS	$ 423,032	$ 100,000	$ 266,217	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 56,815	$ -	$ -	$ -	$ -	$ -	
NEW JERSEY STATE DEPT/HEALTH/SENIOR SRVS	$ 2,394,552	$ 1,638,751	$ 346,382	$ -	$ -	$ -	$ -	$ 169,050	$ 145,567	$ -	$ 94,802	$ -	$ -	$ -	$ -	$ -	
NEW MEXICO STATE DEPARTMENT OF HEALTH	$ 842,783	$ 199,877	$ 326,168	$ 256,398	$ -	$ -	$ -	$ -	$ -	$ -	$ 60,340	$ -	$ -	$ -	$ -	$ -	
NEW YORK STATE DEPT OF HEALTH	$ 1,579,318	$ 400,000	$ 374,166	$ 202,009	$ -	$ -	$ -	$ 307,033	$ 145,567	$ -	$ 150,543	$ -	$ -	$ -	$ -	$ -	
NEW YORK CITY HEALTH/MENTAL HYGIENE	$ 4,520,651	$ 2,060,128	$ 340,392	$ -	$ -	$ -	$ -	$ 393,380	$ 145,567	$ 1,581,184	$ -	$ -	$ -	$ -	$ -	$ -	
NC STATE DEPT/HLTH & HUMAN SERVICES	$ 6,502,181	$ 1,903,858	$ 281,894	$ -	$ 772,104	$ -	$ 3,200,000	$ -	$ 145,567	$ -	$ 198,758	$ -	$ -	$ -	$ -	$ -	
NORTH DAKOTA STATE DEPARTMENT OF HEALTH	$ 238,776	$ 100,000	$ 138,776	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
OHIO STATE DEPARTMENT OF HEALTH	$ 947,460	$ 394,111	$ 298,394	$ -	$ -	$ -	$ -	$ -	$ 145,567	$ -	$ 109,388	$ -	$ -	$ -	$ -	$ -	

NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH	**$ 300,000**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 300,000	$ -
OKLAHOMA STATE DEPARTMENT OF HEALTH	**$ 623,952**	$ 200,000	$ 232,165	$ -	$ -	$ -	$ -	$ 122,817	$ -	$ -	$ 68,970	$ -	$ -	$ -	$ -	$ -
CHEROKEE NATION	**$ 1,760,128**	$1,760,128	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
OREGON STATE PUBLIC HEALTH DIVISION	**$ 2,480,013**	$ 1,860,128	$ 212,318	$ 255,704	$ -	$ -	$ -	$ 82,180	$ -	$ -	$ 69,683	$ -	$ -	$ -	$ -	$ -
NORTHWEST PORTLAND AREA INDIAN HLTH BD	**$ 100,000**	$100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
REPUBLIC OF PALAU MINISTRY OF HEALTH	**$ 184,773**	$ 100,000	$ 84,773	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PENNSYLVANIA STATE DEPT OF HEALTH	**$ 680,942**	$ 400,000	$ 166,089	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 114,853	$ -	$ -	$ -	$ -	$ -
CITY OF PHILADELPHIA PUBLIC HEALTH DEPT	**$ 2,490,102**	$ 1,118,493	$ 183,688	$ -	$ -	$ -	$ -	$ 136,330	$ 145,567	$ 906,024	$ -	$ -	$ -	$ -	$ -	$ -
HERSHEY MILTON S MEDICAL CENTER	**$ 145,567**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 145,567	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PUERTO RICO DEPARTMENT OF HEALTH	**$ 1,450,100**	$ 200,000	$ 156,230	$ -	$ -	$ -	$ -	$ 29,565	$ 145,567	$ 848,326	$ 70,412	$ -	$ -	$ -	$ -	$ -
RHODE ISLAND STATE DEPT OF HEALTH	**$ 396,541**	$ 99,738	$ 296,803	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SOUTH CAROLINA STATE DEPT OF HLTH/ENV	**$ 2,345,092**	$ 200,000	$ 231,176	$ -	$ -	$ -	$ 1,606,981	$ 87,900	$ 145,567		$ 73,468	$ -	$ -	$ -	$ -	$ -
SOUTH DAKOTA STATE DEPT OF HEALTH	**$ 199,447**	$ -	$ 145,267	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 54,180	$ -	$ -	$ -	$ -	$ -

TENNESSEE STATE DEPARTMENT OF HEALTH	**$ 2,108,050**	$ 1,296,995	$ 308,225	$ 181,707	$ -	$ -	$ -	$ 93,161	$ 145,567	$ -	$ 82,395	$ -	$ -	$ -	$ -	$ -
TEXAS STATE DEPT OF HEALTH SERVICES	**$ 2,260,674**	$ 400,000	$ 544,902	$ -	$ 75,148	$ -	$ -	$ 142,681	$ 145,567	$ 850,016	$ 102,360	$ -	$ -	$ -	$ -	$ -
CITY OF SAN ANTONIO METRO HEALTH DIST	**$ 100,000**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DALLAS COUNTY DEPT/HLTH/HUMAN SRVS	**$ 100,000**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HOUSTON CITY HEALTH & HUMAN SERVICES	**$ 1,510,194**	$ 200,000	$ 89,443	$ -	$ -	$ -	$ -	$ 184,076	$ 145,567	$ 891,108	$ -	$ -	$ -	$ -	$ -	$ -
UTAH STATE DEPARTMENT OF HEALTH	**$ 720,650**	$ 200,000	$ 352,662	$ -	$ -	$ -	$ -	$ 104,114	$ -	$ -	$ 63,874	$ -	$ -	$ -	$ -	$ -
VERMONT DEPARTMENT OF HEALTH	**$ 1,319,273**	$ 1,100,000	$ 219,273	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VIRGIN ISLANDS DEPARTMENT OF HEALTH	**$ 149,750**	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ 49,750	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VIRGINIA STATE DEPT OF HEALTH	**$ 987,159**	$ 300,000	$ 251,035	$ -	$ -	$ -	$ -	$ 200,000	$ 145,567	$ -	$ 90,557	$ -	$ -	$ -	$ -	$ -
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS	**$ 1,325,000**	$ 750,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500,000	$ 75,000
WASHINGTON STATE DEPARTMENT OF HEALTH	**$ 999,382**	$ 299,981	$ 510,120	$ -	$ -	$ -	$ -	$ 104,993	$ -	$ -	$ 84,288	$ -	$ -	$ -	$ -	$ -
WEST VIRGINIA STATE DEPT HLTH/HUMAN RSCS	**$ 1,355,811**	$ 1,200,000	$ 96,448	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 59,363	$ -	$ -	$ -	$ -	$ -

WISCONSIN DEPARTMENT OF HEALTH SERVICES	$ 2,530,877	$ 1,960,129	$ 395,014	$ -		$ -	$ -	$ 96,639	$ -	$ -	$ 79,095	$ -	$ -	$ -	$ -	$ -
WYOMING STATE DEPARTMENT OF HEALTH	$ 316,244	$ 100,000	$ 163,444	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 52,800	$ -	$ -	$ -	$ -	$ -
Total Grants and Cooperative Agreements	$ 127,488,503	$ 46,500,000	$ 16,700,000	$ 2,500,000	$ 3,586,555	$ -	$ 29,006,981	$ 5,600,000	$ 4,367,010	$ 13,600,000	$ 3,875,705	$ -	$ -	$ 720,352	$ 2,200,000	$ 832,000
Total Contracts**	$ 54,908,000	$ 1,519,000	$ -	$ -	$ 385,000	$ 3,850,000	$ 5,976,000	$ -	$ -	$ 7,626,000	$ 1,086,000	$ 9,160,000	$ 16,000	$ 18,712,000	$ 2,800,000	$ 3,798,000
Total Other	$ 9,164,000	$ 1,967,000	$ 791,000	$ -	$ 20,000	$ 116,000	$ 1,444,000	$ -	$ -	$ 1,153,000	$ 30,000	$ 340,000	$ 106,000	$ 352,000	$ -	$ 2,865,000
Unobligated	$ 239,797	$ 9,570	$ -	$ 4,901	$ 23,684	$ 14,414	$ 5,560	$ 16,541	$ -	$ -	$ 23,621	$ 278	$ 19,810	$ 92,094	$ 315	$ 4,509
	$ 191,799,900	$ 49,995,570	$ 17,491,000	$ 2,508,901	$ 3,995,239	$ 4,000,414	$ 36,432,541	$ 5,616,541	$ 4,367,010	$ 20,379,000	$ 4,995,326	$ 9,500,278	$ 141,810	$ 19,876,446	$ 5,000,315	$ 7,499,509
FY2010 HHS Allocation	$ 193,800,000	$ 50,000,000		$ 20,000,000	$		44,433,000	$		30,367,000	$	14,500,000	$ 142,000	$ 19,858,000	$ 5,000,000	$ 7,500,000
		$ (4,430)		$ (99)	$		(4,826)	$		(4,449)	$	(4,396)	$ (190)	$ 18,446	$ 315	$ (491)
HHS news releases		9/20/2010	9/24/2010	9/24/2010			9/14/2010	9/24/2011	9/24/2010	9/24/2010	9/24/2010			6/18/2010	6/18/2010	6/18/2010

** This chart does not include information regarding specific contractors.

Health Resources and Services Administration
Prevention Fund by Object Class Expenditure
(WHOLE DOLLARS)

BUREAU	LINE ITEM	41.00 Grants	Other Grant Expenses	Total Obligations
OA	Healthy Weight Collaborative Grant	$4,983,638	$16,362	$5,000,000
MCHB	Nutrition, Physical Activity, & Screen Time Standards	$249,000	$6,000	$255,000
BHPR	State Health Care Workforce Development Grants	$5,623,637	$126,363	$5,750,000
BHPR	Primary Care Residencies	$167,356,219	$1,452,283	$168,808,502
BHPR	Physician Assistant Training	$30,118,081	$0	$30,118,081
BHPR	Traineeships for Nurse Practitioner Students	$31,044,256	$0	$31,044,256
BHPR	Nurse Managed Care Centers	$14,848,096	$1,300	$14,849,396
BHPR	Public Health Training Center Program	$14,829,234	$0	$14,829,234
	TOTAL, PREVENTION FUND	**$269,052,161**	**$1,602,308**	**$270,654,469**

Total Available In Appropration Transfer	**$270,655,000**
Obligation Total in FY 2010	**$270,654,469**
Lapse (Unobligated)	**-$531**

Health Resources and Services Administration
Prevention Fund Awards
Nurse Managed Health Clinics

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nurse Managed Health Clinics

Purpose: To provide federal funding to support the development and operation of Nurse-Managed Health Clinics (NMHC) to: 1) improve access to primary health care, disease prevention and health promotion in medically underserved areas (including enhancements of outreach strategies); 2) enhance nursing practice by increasing the number of structured clinical teaching sites for undergraduate and graduate nursing students; and 3) enhance electronic processes for establishing effective patient and workforce data collection systems. Under this program, the focus would support the training and practice development site for nurse practitioners to build the capacity of primary care provider workforce.

Awardees	City	State	Award Amount
The Regents of the University of California, San Francisco	San Francisco	CA	$1,497,320
University of Colorado, Denver	Aurora	CO	$1,498,206
University of Mississippi Medical Center	Jackson	MS	$1,500,000
Regents of the Univ of Michigan	Ann Arbor	MI	$1,498,577
East Tennessee State University	Johnson City	TN	$1,400,998
Tides Center - Women's Community Clinic	San Francisco	CA	$1,459,366
Fair Haven Community Health Clinic, Inc.	New Haven	CT	$1,500,000
St. Mary's Health Wagon, Inc.	Clinchco	VA	$1,493,634
University of Illinois at Chicago / The Board of Trustees of the University of Illinois	Chicago	IL	$1,499,995
The University of Texas Medical Branch at Galveston	Galveston	TX	$1,500,000
Total, Nurse Managed Health Clinics Grants			**$14,848,096**
Other Grant Expenses			$1,300
Total, Nurse Managed Health Clinics			**$14,849,396**

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expan

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Primary Care Residency Expansion

Purpose: To increase the number of residents trained in primary care specialty - family medicine, general internal and general pediatric medicine. Funding may only be used to increase the enrollment in an accredited primary care residency program through resident stipend support.

Awardees	City	State	Award Amount
Regents of the University of Colorado	Aurora	CO	$1,920,000
Variety Children's Hospital dba Miami Children's Hospital	Doral	FL	$2,861,568
Meharry Medical College	Nashville	TN	$2,880,000
University of Connecticut Health Center	Farmington	CT	$1,890,723
University of Rochester	Rochester	NY	$1,887,125
Board of Trustees of Southern Illinois University	Springfield	IL	$1,869,763
University of Florida	Gainesville	FL	$1,920,000
Swedish Covenant Hospital	Chicago	IL	$960,000
Carilion Medical Center	Roanoke	VA	$1,920,000
The Reading Hospital and Medical Center	Reading	PA	$2,880,000
Children's Hospital & Research Center at Oakland	Oakland	CA	$3,840,000
Providence St Peter Hospital	Olympia	WA	$960,000
UMDNJ - Robert Wood Johnson Medical School	New Brunswick	NJ	$960,000
Albert Einstein Healthcare Network	Philadelphia	PA	$1,920,000
University of Arkansas for Medical Sciences	Little Rock	AR	$1,520,001
University of Arkansas for Medical Sciences-Cancer Research Center	Little Rock	AR	$1,520,001
Yellowstone City & County Health Department/Riverstone Health	Billings	MT	$960,003
University of Arkansas for Medical Sciences-Cancer Research Center	Little Rock	AR	$759,999
The Regents of the University of Michigan	Ann Arbor	MI	$960,000
University of Arkansas	Little Rock	AR	$759,999
The University of Texas Southwestern Medical Center at Dallas	Dallas	TX	$1,920,000
University of Colorado Denver	Aurora	CO	$1,920,000
The Regents of the University of California, San Francisco	San Francisco	CA	$1,920,000
Regents of the University of California	Davis	CA	$1,920,000
The Regents of the University of California, Los Angeles	Los Angeles	CA	$1,920,000
University of Medicine and Dentistry of New Jersey	Stratford	NJ	$1,920,000
Univ. of Mass. Medical School	Worcester	MA	$960,000
The Regents of the University of California, San Francisco	San Francisco	CA	$1,920,000
Children's Hospital of Pittsburgh of the UPMC Health System	Pittsburgh	PA	$1,920,000
The Ohio State University	Columbus	OH	$3,840,000

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expan

Awardees	City	State	Award Amount
Boston Medical Center	Boston	MA	$3,840,000
Idaho State University	Pocatello	ID	$960,000
Community Hospitals Foundation	Indianapolis	IN	$960,000
Curators, University of Missouri on behalf of UMKC	Kansas City	MO	$1,920,000
Central Iowa Hospital Corporation	Des Moines	IA	$1,920,000
Texas Tech Univ Health Sciences Center	Lubbock	TX	$960,000
Community Health of Central Washington	Yakima	WA	$1,920,000
Newark Beth Israel Medical Center	Newark	NJ	$1,920,000
Baystate Medical Center	Springfield	MA	$3,840,000
Virginia Commonwealth University	Richmond	VA	$1,585,520
Variety Children's Hospital dba Miami Children's Hospital	Doral	FL	$1,907,712
The Family Medicine Residency of Idaho, Inc.	Boise	ID	$960,000
Board of Regents, University of Nevada, Reno	Reno	NV	$960,000
Children's National Medical Center	Washington	DC	$3,840,000
Tulane University, School of Medicine	New Orleans	LA	$2,472,964
Baylor College of Medicine	Houston	TX	$1,920,000
Catholic Healthcare West / St. Mary Medical Center	Long Beach	CA	$1,920,000
Baylor Research Institute	Dallas	TX	$960,000
Mount Auburn Hospital	Cambridge	MA	$2,879,998
The Family Medicine Residency of Idaho, Inc.	Boise	ID	$960,000
Cincinnati Children's Hospital Medical Center	Cincinnati	OH	$1,872,024
Crozer-Chester Medical Center	Upland	PA	$1,920,000
UPMC Presbyterian Shadyside	Pittsburgh	PA	$960,000
Montefiore Medical Center	Bronx	NY	$1,490,111
Freeman Oak Hill Health System	Joplin	MO	$1,907,712
Texas Tech University Health Sciences Center	Lubbock	TX	$1,920,001
Newark Beth Israel Medical Center	Newark	NJ	$1,920,000
Spectrum Health Hospitals	Grand Rapids	MI	$3,490,659
Regents of the University of California	San Francisco	CA	$1,920,000
Cooper Health System D/B/A Cooper University Hospital	Camden	NJ	$1,920,000
Group Health Cooperative	Seattle	WA	$960,000
Medical University of South Carolina	Charleston	SC	$1,920,000
Danbury Hospital	Danbury	CT	$3,360,000
Kingsbrook Jewish Medical Center	Brooklyn	NY	$2,880,000
Richmond Medical Center	Staten Island	NY	$2,880,000
Johns Hopkins University	Baltimore	MD	$3,839,998
The University of Illinois at Chicago	Chicago	IL	$1,920,000
Bronx-Lebanon Hosp Ctr	Bronx	NY	$2,880,000
Cooper Health System D/B/A Cooper University Hospital	Camden	NJ	$1,920,000
Marshfield Clinic Research Foundation	Marshfield	WI	$1,920,000
Bronx-Lebanon Hosp Ctr	Bronx	NY	$2,880,000
Sisters of Charity Hospital	Buffalo	NY	$1,912,499
Hennepin Healthcare System, Inc./Hennepin County Medical Center	Minneapolis	MN	$1,918,827
Louisiana State University Health Science Center	New Orleans	LA	$3,120,000
Curators, University of Missouri on behalf of UMKC	Kansas City	MO	$1,920,000

Health Resources and Services Administration
Prevention Fund Awards
Primary Care Residency Expan

Awardees	City	State	Award Amount
Regents of University of California	La Jolla	CA	$2,880,000
Marshfield Clinic Research Foundation	Marshfield	WI	$1,920,000
Baystate Medical Center	Springfield	MA	$2,880,000
University of North Carolina at Chapel Hill	Chapel Hill	NC	$3,715,684
St. Elizabeth Medical Center	Utica	NY	$1,920,000
New Hanover Regional Medical Center	Wilmington	NC	$1,795,571
University of Pennsylvania	Philadelphia	PA	$2,777,757
Subtotal, Primary Care Residency Expansion Grants			**$167,356,219**
Other Grant Expenses			$1,452,283
Total, Primary Care Residency Expansion			**$168,808,502**

Health Resources and Services Administration
Prevention Fund Awards
Healthy Weight

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Healthy Weight Collaborative

Purpose: To create and manage a new Prevention Center for Healthy Weight to address obesity in children and families. The center will launch the Healthy Weight Collaborative to share evidence-based and promising community-based and clinical interventions in preventing and treating obesity.

Awardees	City	State	Award Amount
National Initiative for Children's Healthcare Quality	Boston	MA	$4,983,638
Total, Healthy Weight Collaborative Grants			**$4,983,638**
Other Grant Expenses			$16,362
Total, Healthy Weight Collaborative			**$5,000,000**

Health Resources and Services Administration
Prevention Fund Awards
Physician Assistant Training

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Physician Assistant Training

Purpose: To increase student enrollment in primary care physician assistant programs and graduates planning to practice primary care specialties.

Awardees	City	State	Award Amount
Lincoln Memorial University	Harrogate	TN	$1,900,800
Miami Dade College Medical Center Campus	Miami	FL	$641,520
Shenandoah University	Winchester	VA	$1,069,200
University of Nebraska Medical Center	Omaha	NE	$924,000
The University of Toledo Health Science Campus	Toledo	OH	$1,009,880
Pace University	New York	NY	$660,000
Duke University Medical Center	Durham	NC	$1,320,000
University of Utah	Salt Lake City	UT	$704,000
Union College	Lincoln	NE	$792,000
University of New Mexicio Health Sciences Center	Albuquerque	NM	$204,239
Desales University	Center Valley	PA	$704,000
Riverside Community College District/Moreno Valley Campus	Moreno Valley	CA	$2,117,808
Methodist University, Inc.	Fayetteville	NC	$1,188,000
University of Colorado Denver	Aurora	CO	$855,360
Grand Valley State University	Grand Rapids	MI	$1,791,720
University of Washington	Seattle	WA	$1,980,000
University of Texax - Pan American	Edinburg	TX	$1,980,000
Samuel Merritt College	Oakland	CA	$1,232,000
State of Colorado for Red Rocks Community College	Lakewood	CO	$399,495
Chatham University	Pittsburgh	PA	$880,000
King's College	Wilkes Barre	PA	$990,000
LeMoyne College	Syracuse	NY	$1,056,000
New York Institute of Technology	Old Westbury	NY	$855,360
University of New England	Biddeford	ME	$990,000
The Research Foundation of SUNY	Albany	NY	$2,046,528
University of Southern California	Los Angeles	CA	$704,000
Marywood University	Scranton	PA	$704,000
The Univ of Oklahoma Health Sciences Center	Oklahoma City	OK	$418,171
Total, Physician Assistant Training Grants			**$30,118,081**

Health Resources and Services Administration
Prevention Fund Awards
State Health Care Workforce Dvl

Health Resources and Services Administration
State Health Workforce Development Grants

Purpose: To enable State partnerships (1) to complete comprehensive health care workforce development planning and (2) to implement those plans or carry out activities as defined by the State application in order to address current and projected workforce demands within the State.

Awardees	City	State	Award Amount
Virginia State Department of Health	Richmond	VA	$1,935,137
Univ of Wisconsin - Madison	Madison	WI	$150,000
NJ Department of Labor and Workforce	Trenton	NJ	$150,000
District of Columbia Department of Employment Services	Washington	DC	$149,250
Idaho Department of Labor	Boise	ID	$150,000
University of North Dakota	Grand Forks	ND	$150,000
MN Department of Employment and Economic Development	Saint Paul	MN	$149,599
Maryland Governor's Workforce Investment Board	Baltimore	MD	$150,000
State of Ohio - Department of Health	Columbus	OH	$150,000
Wyoming Department of Workforce Services	Cheyenne	WY	$149,396
Nevada Dept of Employment, Training, and Rehabilitation	Carson City	NV	$149,999
Montana State University	Bozeman	MT	$150,000
Connecticut Employment & Training Commission	Wethersfield	CT	$150,000
North Carolina Department of Commerce Division of Workforce Development	Raleigh	NC	$144,595
Colorado Department of Public Health and Environment	Denver	CO	$150,000
University of Vermont	Burlington	VT	$131,786
New Mexico Department of Labor	Albuquerque	NM	$150,000
Hawaii Department of Labor and Industrial Relations	Honolulu	HI	$150,000
New York State Department of Labor	Albany	NY	$150,000
California Department of Employment Development	Sacramento	CA	$150,000
Alaska Department of Labor and Workforce Development, ESD	Juneau	AK	$150,000
Commonwealth Corporation	Boston	MA	$149,271
South Carolina Department of Employment and Workforce	Columbia	SC	$114,604
Kansas Department of Commerce	Topeka	KS	$150,000
Pennsylvania Department of Labor & Industry	Harrisburg	PA	$150,000
Maine Jobs Council	Augusta	ME	$150,000
Total, State Health Workforce Development Grants			**$5,623,637**

Health Resources and Services Administration
Prevention Fund Awards
Nurse Practitioner Traineeships

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nurse Practioner Traineeships

Purpose: To provide financial support through traineeships for registered nurses enrolled in advanced education nursing programs to prepare nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse administrators, nurse educators, public health nurses and nurses in other specialties determined by the Secretary to require advanced education.

Awardees	City	State	Award Amount
Case Western Reserve Univ	Cleveland	OH	$1,425,600
Univ of Utah	Salt Lake City	UT	$1,425,600
Western Univ of Health Sciences	Pomona	CA	$1,056,000
Univ of Oklahoma Health Sciences Center	Oklahoma City	OK	$807,840
Florida State University	Tallahassee	FL	$1,425,600
East Tennessee State University	Johnson City	TN	$1,425,600
Univ of Illinois at Chicago /The Board of Trustees of the University of Illinois	Chicago	IL	$1,425,600
West Virginia University Rsch Corp	Morgantown	WV	$950,400
Shenandoah Univ	Winchester	VA	$1,188,000
Univ of Massachusettes Medical School	Worcester	MA	$760,816
Univ of Detroit Mercy	Detroit	MI	$760,320
Pace Univ	New York	NY	$1,425,600
Wayne State University	Detroit	MI	$1,320,000
Oregon Health & Science University	Portland	OR	$1,283,040
Michigan State Univ	East Lansing	MI	$1,425,600
Trustees of the Univ of Pennsylvania	Philadelphia	PA	$950,400
College of St. Scholastica	Duluth	MN	$1,330,560
Georgia State Univ Research Foundation, Inc.	Atlanta	GA	$831,600
The University of Michigan-Flint	Flint	MI	$1,425,600
Univ of Texas Health Science Center at San Antonio	San Antonio	TX	$1,425,600
Rutgers, The State University	Newark	NJ	$807,840
University of Miami	Miami	FL	$704,000
Duke Univ School of Nursing	Durham	NC	$1,276,000
The Pennsylvania State Univ	University Park	PA	$1,335,840
Daemen College	AMHERST	NY	$1,425,600
Medical Univ of South Carolina	Charleston	SC	$1,425,600
Total, Nurse Practioner Traineeship Grants			**$31,044,256**

Health Resources and Services Administration
Prevention Fund Awards
Nutrition, Physical Activity

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Nutrition, Physical Activity, & Screen Time Standards

Purpose: To identify content and strategies to assist States and selected Territories, child care providers and early educators, as well as families of young children, in preventing childhood obesity.

Awardees	City	State	Award Amount
University of Colorado HSC	Aurora	CO	$249,000
Total, Nutrition, Physical Activity, and Screen Time Stds Grants			**$249,000**
Other Grant Costs			$6,000
Total, Nutrition, Physical Activity, and Screen Time Stds			**$255,000**

Health Resources and Services Administration
Prevention Fund Awards
Public Health Training Centers

FY 2010 Prevention and Public Health Fund
Health Resources and Services Administration
Public Health Training Centers

Purpose: To improve the Nation's public health system by strengthening the technical, scientific, managerial, and leadership competence of the current and future public health workforce. A public health training center plans, develops, operates, and evaluates projects that are in furtherance of the goals established by the Secretary in the areas of preventive medicine, health promotion and disease prevention, or improving access to and quality of health services in medically underserved communities.

Organization Name	City	State	Total
University of South Florida	Tampa	FL	$650,000
UMDNJ-School of Public Health	New Brunswick	NJ	$647,654
The Research Foundation of SUNY	Albany	NY	$649,921
INDIANA UNIVERSITY	Indianapolis	IN	$129,267
University of Puerto Rico Medical Sciences Campus	San Juan	PR	$650,000
University of Kentucky Research Foundation	Lexington	KY	$647,307
The Regents of the University of California	Berkeley	CA	$649,819
The University of Georgia	Athens	GA	$630,032
Arizona Board of Regents	Tucson	AZ	$647,637
The Univ of Texas Health Science Center at Houston	Houston	TX	$649,801
Trustees of Boston University, BUMC	Boston	MA	$649,977
Eastern Virginia Medical School	Norfolk	VA	$488,360
University of Colorado Denver	Aurora	CO	$649,497
Trustees of Dartmouth College	Hanover	NH	$618,734
East Tennessee State Univ	Johnson City	TN	$650,000
Regents of the University of California, Los Angeles	Los Angeles	CA	$650,000
Univ of Pittsburgh	Pittsburgh	PA	$649,994
University of Washington	Seattle	WA	$650,000
The University of Oklahoma Health Sciences Center	Oklahoma City	OK	$649,750
Board of Regents of the University of Wisconsin System	Madison	WI	$628,480
University of South Carolina	Columbia	SC	$650,000
Emory University	Atlanta	GA	$650,000
The Regents of the Univ of Michigan	Ann Arbor	MI	$650,000
Univ of North Carolina at Chapel Hill	Chapel Hill	NC	$643,004
Total, Public Health Training Centers			**$14,829,234**