

**DEPARTMENTS OF LABOR, HEALTH AND  
HUMAN SERVICES, AND EDUCATION, AND  
RELATED AGENCIES APPROPRIATIONS FOR  
FISCAL YEAR 2013**

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**WEDNESDAY, MARCH 7, 2012**

U.S. SENATE,  
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,  
*Washington, DC.*

The subcommittee met at 10:05 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Kohl, Landrieu, Pryor, Mikulski, Brown, Shelby, Alexander, Johnson, Graham, and Moran.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

**STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY**

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies will come to order.

Madam Secretary, welcome back to the subcommittee. I want to start by commending you for the outstanding work you are doing to implement the Affordable Care Act (ACA) since President Obama signed it into law almost 2 years ago.

Some 3.6 million seniors—more than 42,000 in my State of Iowa—got discounts on their prescription drugs last year. Two-and-a-half million young adults are staying on their parents' insurance from graduation to age 26. I just ran into a family in Iowa where a student got off the family insurance, and then lost their job. That person came back on the family's insurance, went back to school again, took the college insurance, got out of school, came back on their family's insurance. And so it was a great comfort to this family to know that their child would not be without insurance coverage and they got insurance at the family rate.

Most important of all, 54 million Americans received a free preventative screening service in 2011 all because of ACA. And I believe this is the right track for healthcare in America. You know how strongly I feel about prevention and wellness.

Your Department is carrying out these reforms with great skill and dedication, and I commend you for your leadership.

More work remains, of course. Fiscal year 2013 is a key year for implementing ACA because it ends just 3 months before health insurance exchanges will open their doors in the States. On that day, we will fulfill a promise to bring affordable healthcare to 30 million uninsured Americans.

The President's budget request for fiscal year 2013 includes additional funding at Centers for Medicare & Medicaid Services (CMS) for creating these exchanges. As the chairman of this subcommittee and also of the authorizing committee, I am determined to help you finish the job. Reforming healthcare is not only the right thing to do, it will save taxpayers money and reduce the deficit and again move us more toward a real healthcare system rather than a sick care system.

The President's proposed budget also includes increases for key priorities like child care, Head Start, and rooting out fraud, waste, and abuse in Medicare and Medicaid.

However, there were two areas in which I was disappointed. One area is, of course, the cuts in the budget for the prevention fund. The prevention fund is something that was worked out in great detail, and all the different compromises were made when we passed the ACA. And then the President requested a cut of \$4.5 billion, which was then folded in the recent agreement by the Congress for a \$5 billion cut in the prevention fund, again penny wise, pound foolish. We will just take funding away from prevention, but boy, when you get sick, we will take care of you later on and it will cost us a lot more money. I do not know when we are going to learn that our mothers were right. An ounce of prevention is worth a pound of cure. And that is true in healthcare. But no. Take money out of the prevention fund.

The other part where I am disappointed is the lack of any additional funding for eliminating fraud and waste in healthcare. I chaired a hearing on this topic last February. Every \$1 that CMS spends on reducing fraud and waste returns \$7 to the U.S. Treasury in real dollars. The Budget Control Act of 2011 included a cap adjustment that encouraged the Congress to increase this funding by \$270 million, an amount that would have saved taxpayers well over \$1 billion. Yet, in conference at the insistence of the House majority, they refused any additional funding for this whatsoever in last year's bill. Again, penny wise and pound foolish.

I am pleased that the President has once again requested an increase for eliminating healthcare waste and abuse in this year's budget. And I would like to discuss this topic more with you later.

Some other provisions in the President's budget meanwhile are cause for concern. Once again, the President has proposed a nearly 50 percent cut to the Community Services Block Grants. This funding is critically important for community initiatives that provide a safety net for millions of low-income people across the country. The Congress rejected that cut last year. I expect it will do so again this year.

But overall, I believe the President's budget is a good start.

## PREPARED STATEMENT

Madam Secretary, again, I commend you for your great leadership in these areas and especially what you are doing to implement ACA, and I look forward to hearing your testimony.

First, before I yield to the ranking member, Senator Shelby, for his opening remarks, I have received a statement from the full committee chairman, Senator Inouye. His statement will be inserted into the record at this point.

[The statement follows:]

## PREPARED STATEMENT OF CHAIRMAN DANIEL K. INOUE

Mr. Chairman, thank you for chairing this hearing to review the President's fiscal year 2013 budget for the Department of Health and Human Services.

I would like to extend a warm aloha to Secretary of Health and Human Services, Kathleen Sebelius. These are challenging fiscal times, but I look forward to continuing to work with her to support critical investments in healthcare, disease prevention, social services, and scientific research.

Senator HARKIN. Senator Shelby.

## STATEMENT OF SENATOR RICHARD C. SHELBY

Senator SHELBY. Thank you, Mr. Chairman.

Secretary Sebelius, thank you for appearing today to discuss the fiscal year 2013 Department of Health and Human Services (HHS) budget.

We are living in difficult times. America's gross debt has increased more than \$5 trillion during President Obama's first 3 years in office, and the fiscal year 2013 budget request does nothing to curb spending or put our country on a fiscally sustainable path. In fact, the administration has built the fiscal year 2013 budget based, I believe, on the flawed philosophy of spend now, pay later. But as the turmoil in Greece is verifying, at some point the bill must be paid.

One of the key fiscal challenges facing the Federal Government is healthcare spending. In the last 20 years, total funding for HHS has tripled. Since 2001, the HHS's discretionary appropriation has increased by 45 percent. The President's answer to control health spending, the Affordable Care Act (ACA) that Senator Harkin referenced, continues to grow our Nation's deficit, and its bills are piling up.

In the fiscal year 2013, the budget requests a \$1 billion increase in discretionary dollars for the Centers for Medicare & Medicaid Services to continue implementation of ACA activities. This is in addition to the \$15.4 billion in mandatory funding ACA directly appropriated since fiscal year 2011. By combining discretionary and mandatory funding streams, the majority of ACA circumvents the yearly appropriations process that is crucial to providing transparency and oversight to funding decisions.

As we attempt to rein in Federal spending, it is clear that a comprehensive view to fund the healthcare programs is necessary. Instead of using budgetary smoke and mirrors, I believe we should examine all sources of funding, discretionary and mandatory, before the Appropriations Committee here determines an appropriate level of discretionary funding. Many programs advertise their baseline reduction when, in fact, they are recipients of significant man-

datory funding from ACA. Agencies and programs I believe should no longer deceive the American taxpayer by arguing that spending is reduced when they also receive mandatory funding from ACA that supplements and, in many cases, greatly increases their spending level.

It is also critical here that our subcommittee carefully consider the effects of ACA's mandatory funding on important healthcare programs that may not be able to continue if the act is not repealed. The administration has used ACA's mandatory spending, which is not subject to a vote by the Congress every year, to back-fill key and discretionary programs. The administration then diverts discretionary dollars to fund new programs. If ACA is repealed, many important programs like community health centers and the section 317 immunization program at the Centers for Disease Control will be in jeopardy because their base funding provided by the Department of Labor, HHS appropriations has been so significantly reduced.

I believe it is time to stop deceptive budgeting. We should be looking at the resources programs need for the fiscal year and not necessarily their long-enjoyed funding history. The Congress should carefully review programs to ensure funding is targeted to those that are the most successful and achieve the best results.

#### PREPARED STATEMENT

That is why I am disappointed that the administration has cut funding for the National Institutes of Health (NIH). In the last 30 years, biomedical research has yielded significant scientific discoveries that have extended life, reduced illness, and cut healthcare costs considerably. Secretary Sebelius, your budget request, I believe, abandons our Nation's commitment to advancing medical research. In fact, the request does not keep pace with biomedical research inflation, and as a result, in inflationary adjusted dollars, NIH is nearly 20 percent below where they were just 10 years ago. Our Nation's leading researchers will never find a cure, I believe, for the debilitating diseases that affect us without a commitment to advancing medical research. I believe it is critical to invest in biomedical research to ensure the United States continues to make progress toward medical discoveries that improve our lives and make treatment more effective and lower overall healthcare costs.

I look forward to hearing from you this morning, but these are some of the concerns that I think we should look at.

[The statement follows:]

#### PREPARED STATEMENT OF SENATOR RICHARD C. SHELBY

Secretary Sebelius, thank you for appearing today to discuss the Department of Health and Human Services (HHS) fiscal year 2013 budget.

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In fact, the administration has built the 2013 budget based on the flawed philosophy of spend now, pay later. But as the turmoil in Greece is verifying, at some point the bill must be paid.

One of the key fiscal challenges facing the Federal Government is healthcare spending. In the last 20 years, total funding for HHS has tripled. Since 2001, the Department's discretionary appropriation has increased by 45 percent.

The President's answer to control health spending, the Affordable Care Act (ACA), continues to grow our Nation's deficit, and its bills are piling up.

In fiscal year 2013, the budget requests a \$1 billion increase in discretionary dollars for the Centers for Medicare & Medicaid Services to continue implementation of ACA activities. This is in addition to the \$15.4 billion in mandatory funding the ACA directly appropriated since fiscal year 2011. By combining discretionary and mandatory funding streams, the majority of ACA circumvents the yearly appropriations process that is crucial to providing transparency to funding decisions.

As we attempt to rein in Federal spending, it is clear that a comprehensive view to fund healthcare programs is necessary.

Instead of using budgetary smoke and mirrors, we should examine all sources of funding—discretionary and mandatory—before the Appropriations Committee determines an appropriate level of discretionary funding. Many programs advertise their baseline reduction, when, in fact, they are recipients of significant mandatory funding from ACA. Agencies and programs should no longer deceive the American taxpayer by arguing their spending is reduced when they also receive mandatory funding from ACA that supplements and, in many cases, greatly increases their spending level.

It is also critical that our subcommittee carefully consider the effects of the ACA's mandatory funding on important healthcare programs that may not be able to continue when the act is repealed. The administration has used the ACA's mandatory spending, which is not subject to a vote by the Congress every year, to backfill key discretionary programs. The administration then diverts discretionary dollars to fund new programs.

When ACA is repealed, many important programs like community health centers and the section 317 immunization program at the Centers for Disease Control will be in jeopardy because their base funding provided by the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill has been so significantly reduced.

It is time to stop deceptive budgeting. We should be looking at the resources programs need for this fiscal year and not necessarily their long-enjoyed funding history. The Congress should carefully review programs to ensure funding is targeted to those that are the most successful and achieve the best results.

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Our Nation's leading researchers will never find a cure for the debilitating diseases that affect us without a commitment to advancing medical research. It is critical to invest in biomedical research to ensure the United States continues to make progress towards medical discoveries that improve lives, make treatment more effective, and lower overall healthcare costs.

Mr. Chairman, I look forward to working with you this year to craft a bill that balances the needs of our healthcare system within our country's fiscal restraints.

Senator SHELBY. Thank you, Mr. Chairman.

Senator HARKIN. Thank you very much, Senator Shelby.

Kathleen Sebelius became the 21st Secretary of the Department of Health and Human Services on April 29, 2009. In 2003, she was elected Governor of Kansas and served in that capacity until her appointment by President Obama as the Secretary. Prior to her election as Governor, she served as the Kansas State Insurance Commissioner. She is a graduate of Trinity Washington University and the University of Kansas.

My notes tell me this will make the Secretary's fifth appearance before this subcommittee since her appointment. You have always been forthright with us, Madam Secretary. We appreciate your being here. Your statement will be made a part of the record in its entirety, and please proceed as you so desire.

## SUMMARY STATEMENT OF KATHLEEN SEBELIUS

Secretary SEBELIUS. Well, thank you, Chairman Harkin and Ranking Member Shelby, and members of the subcommittee. A little shout-out to my home State senator, Senator Moran. And I appreciate the invitation to discuss the President's fiscal year 2013 budget for HHS.

Our budget helps create an American economy built to last by strengthening our Nation's healthcare, supporting research that will lead to tomorrow's cures, and promoting opportunities for America's children and families so everyone has a fair shot to reach his or her potential. It makes the investments we need right now, while reducing the deficit in the long term, to make sure that the programs that millions of Americans rely on will be there for generations to come.

I look forward to our discussion and answering your questions about the budget. But first, I would like to just share some of the highlights that fall under the jurisdiction of this subcommittee, which oversees almost \$70 billion of our Department's nearly \$77 billion discretionary budget.

## HEALTHCARE REFORM

Over the last 2 years, as the chairman said, we have worked to deliver the benefits of ACA to the American people. Thanks to the law, more than 2.5 million additional young Americans are already getting coverage through their parents' health plans. More than 25 million seniors across the country have taken advantage of the free recommended preventive services under Medicare. And small business owners are getting tax breaks on their health bills that allow them to hire more employees.

This year, we will build on that progress by continuing to support States as they work to establish affordable insurance exchanges by 2014. Once these competitive marketplaces are in place, they will ensure that all Americans have access to quality, affordable health coverage.

Because we know that a lack of insurance is not the only obstacle to care, our budget also invests in the healthcare workforce. This budget supports training more than 7,100 primary care providers and placing them where they are needed most.

It also invests in America's network of community health centers. Together with the 2012 resources, our budget will create more than 240 new access points for patient care, along with thousands of new jobs. Altogether, health centers will provide access to quality care for 21 million people, 300,000 more than were served last year.

This budget also continues our administration's commitment to improving the quality and safety of care by spending health dollars more wisely. It means investing in health information technology. It also means funding the first-of-its-kind Center for Medicare and Medicaid Innovation which is partnering with physicians, nurses, hospital administrators, private payers, and others who have accepted the challenge to develop a new, sustainable healthcare system.

In addition, our budget ensures that 21st century America will continue to lead the world in biomedical research by maintaining funding for NIH.

#### HEALTHCARE WASTE, FRAUD, AND ABUSE

At the same time, the budget recognizes the need to set priorities, making difficult tradeoffs and ensure we use every \$1 wisely. That starts with support for President Obama's historic push to stamp out waste, fraud, and abuse in the healthcare system. Over the last 3 years, every \$1 we have put into healthcare fraud and abuse control has returned more than \$7 to taxpayers. Last year alone, these efforts recovered more than \$4 billion. And just last week, our administration arrested the alleged head of the largest individual Medicare and Medicaid fraud operation in history. Our budget builds on those efforts by giving law enforcement the technology and data to spot perpetrators early and prevent payments based on fraud from going out in the first place.

The budget also contains more than \$360 billion in health savings over 10 years, most of which comes from reforms to Medicare and Medicaid. These are significant, but they are carefully crafted to protect beneficiaries. For example, we propose significant savings in Medicare by reducing drug costs, a plan that both puts money back in the Medicare Trust Fund and puts money back in the pockets of Medicare beneficiaries.

#### PREPARED STATEMENT

The budget makes smart investments where they will have the greatest impact, and it puts us all on a path to build a stronger, healthier, more prosperous America for the future.

Again, thank you, Mr. Chairman and members of the subcommittee, and I look forward to this discussion.

[The statement follows:]

#### PREPARED STATEMENT OF KATHLEEN SEBELIUS

Chairman Harkin, Ranking Member Shelby, and members of the subcommittee, thank you for the invitation to discuss the President's fiscal year 2013 budget for the Department of Health and Human Services (HHS).

The budget for HHS invests in healthcare, disease prevention, social services, and scientific research. HHS makes investments where they will have the greatest impact, build on the efforts of our partners, and lead to meaningful gains in health and opportunity for the American people.

The President's fiscal year 2013 budget for HHS includes a reduction in discretionary funding for ongoing activities and legislative proposals that would save an estimated \$350.2 billion over 10 years. The budget totals \$940.9 billion in outlays and proposes \$76.7 billion in discretionary budget authority, including \$69.6 billion under the purview of this subcommittee. This funding will enable HHS to:

- strengthen healthcare;
- support American families;
- advance scientific knowledge and innovation;
- strengthen the Nation's health and human service infrastructure and workforce;
- increase efficiency, transparency, and accountability of HHS programs; and
- complete the implementation of the American Recovery and Reinvestment Act.

#### STRENGTHEN HEALTHCARE

*Delivering Benefits of the Affordable Care Act (ACA) to the American People.*—The ACA expands access to affordable health coverage to millions of Americans, increases consumer protections to ensure individuals have coverage when they need it most, and slows increases in health costs. Effective implementation of the ACA

is central to the improved fiscal outlook and well-being of the Nation. The Centers for Medicare & Medicaid Services (CMS) is requesting an additional \$1 billion in discretionary funding to continue implementing the ACA, including Affordable Insurance Exchanges, and to help keep up with the growth in the Medicare population.

*Expand and Improve Health Insurance Coverage.*—Beginning in 2014, Affordable Insurance Exchanges will provide improved access to insurance coverage for millions of Americans. Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop shopping where they can compare benefit plans. New premium tax credits and reductions in cost-sharing will help ensure that eligible individuals can afford to pay for the cost of private coverage through Exchanges. Fiscal year 2013 will be a critical year for building the infrastructure and initiating the many business operations critical to enabling Exchanges to begin operation on January 1, 2014. The expansion of health insurance coverage for millions of low-income individuals, who were previously not eligible for coverage, also begins in 2014. CMS has worked closely with States to ensure they are prepared to meet the 2014 deadline and will continue this outreach in fiscal year 2013.

Many important private market reforms have already gone into effect, providing new rights and benefits to consumers that are designed to put them in charge of their own healthcare. The ACA's Patient's Bill of Rights allows young adults to stay on their parents' plans until age 26 and ensures that consumers receive the care they need when they get sick and need it most by prohibiting rescissions and lifetime dollar limits on coverage for care, and beginning to phase out annual dollar limits. The new market reforms also guarantee independent reviews of coverage disputes. Temporary programs like the Early Retiree Reinsurance Plan and the Pre-Existing Condition Insurance Plan are supporting affordable coverage for individuals who often face difficulties obtaining private insurance in the current marketplace. Additionally, rate review and medical loss ratio (MLR) provisions helps ensure that healthcare premiums are kept reasonable and affordable year after year. The already operational rate review provision gives States additional resources to determine if a proposed healthcare premium increase is unreasonable and, in many cases, help enable State authorities to deny an unreasonable rate increase. HHS reviews large proposed increases in States that do not have effective rate review programs. The MLR provisions guarantee that, starting in 2011, insurance companies use at least 80 percent or 85 percent of premium revenue, depending on the market, to provide or improve healthcare for their customers or give them a rebate.

*Strengthen the Delivery System.*—ACA established a Center for Medicare and Medicaid Innovation. The Innovation Center is tasked with developing, testing, and—for those that prove successful—expanding innovative payment and delivery system models to improve quality of care and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program. Since the Innovation Center began operations it has undertaken an ambitious agenda encompassing patient safety, coordination of care among multiple providers, and enhanced primary care. These projects can serve as crucial stepping stones towards a higher-quality, more-efficient healthcare system.

*Ensuring Access to Quality Care for Vulnerable Populations.*—Health centers are a key component of the Nation's healthcare safety net. The President's budget includes a total of \$3 billion, including an increase of \$300 million from mandatory funds under the ACA, to the health centers program. This investment will provide Americans in underserved areas—both rural and urban—with access to comprehensive primary and preventive healthcare services. Together with 2012 resources, HHS' budget will create more than 240 new access points for patient care. Overall, HHS' investment in health centers will provide access to quality care for 21 million people, an increase of 300,000 additional patients over fiscal year 2012. The budget also promotes a policy of steady and sustainable health center growth by distributing ACA resources over the long-term. This policy safeguards resources for new and existing health centers to continue services and ensures a smooth transition as health centers increase their capacity to provide care as access to insurance coverage expands.

*Improving Healthcare Quality and Patient Safety.*—ACA directed HHS to develop a national strategy to improve healthcare services delivery, patient health outcomes, and population health. In fiscal year 2011, HHS released the National Strategy for Quality Improvement in Health Care, which highlights three broad aims:

- better care;
- healthy people and communities; and
- affordable care.

Since publishing the National Strategy for Quality Improvement in Health Care, HHS has focused on gathering additional input from private partners and aligning new and existing HHS activities with the strategy. HHS will enhance the strategy by incorporating input from stakeholders and developing metrics to measure progress toward achieving the strategy's aims and priorities. Already, the strategy is serving as a blueprint for quality improvement activities across the country.

*Investing in Innovation.*—HHS is committed to advancing the use of health information technology (IT). The budget includes \$66 million, an increase of \$5 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate the adoption of health IT and promote electronic health records (EHRs) as tools to improve both the health of individuals and the healthcare system as a whole. The increase will allow ONC to provide more assistance to healthcare providers as they become meaningful users of health IT. Furthermore, through the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act, CMS is providing hospitals and medical professionals who participate in Medicare and Medicaid with substantial incentive payments for the adoption and meaningful use of EHRs. As of February 1, 2012, CMS had made incentive payments to more than 23,600 providers who have met the objectives for meaningful use in the Medicare EHR Incentive program and more than 19,600 providers who have adopted, implemented, or upgraded EHRs, or met meaningful use objectives in the Medicaid EHR Incentive program. By encouraging providers to modernize their systems, this investment will improve the quality of care and protect patient safety.

#### SUPPORT AMERICAN FAMILIES

*Healthy Development of Children and Families.*—HHS oversees many programs that support children and families. The fiscal year 2013 budget request invests in early education, recognizing the role high-quality early education programs can play in preparing children for school success.

*Investing in Education by Supporting an Early Learning Reform Agenda.*—The fiscal year 2013 budget supports critical reforms in Head Start and a child care quality initiative that, when taken together with the Race to the Top—Early Learning Challenge, are key elements of the administration's broader education reform agenda designed to improve our Nation's competitiveness by helping every child enter school ready for success.

On November 8, 2011, the President announced important new steps to improve the quality of services and accountability at Head Start centers across the country. The budget requests more than \$8 billion for Head Start programs, an increase of \$85 million more than fiscal year 2012, to maintain services for the 962,000 children currently participating in the program. This investment will also provide resources to effectively implement new regulations that require grantees that do not meet high-quality benchmarks to compete for continued funding, introducing an unprecedented level of accountability into the Head Start program. By directing taxpayer dollars to programs that offer high-quality Head Start services, this robust, open competition for Head Start funding will help to ensure that Head Start programs provide the best available early education services to our most vulnerable children.

The budget includes \$300 million for a new child care quality initiative that States would use to invest directly in programs and teachers so that individual child care programs can do a better job of meeting the early learning and care needs of children and families. The funds would also support efforts to measure the quality of individual child care programs through a rating system or another system of quality indicators, and to clearly communicate program-specific information to parents so they can make informed choices for their families. These investments are consistent with the broader reauthorization principles outlined in the budget, which encompass a reform agenda that would help transform the Nation's child care system to one that is focused on continuous quality improvement and provides more low-income children access to high-quality early education settings that support children's learning, development, and success in school.

*Keeping America Healthy.*—The President's budget includes resources necessary to enhance clinical and community prevention, support research, develop the public health workforce, control infectious diseases, and invest in prevention and management of chronic diseases and conditions.

*Tobacco Prevention Activities.*—Tobacco use kills an estimated 443,000 people in the United States each year. Despite progress in reducing tobacco use, 1 in 5 high school students and adults continue to smoke, costing our Nation \$96 billion in medical costs and \$97 billion in lost productivity each year. The budget includes \$586 million in funding from the Centers for Disease Control and Prevention (CDC), the

National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to further help reduce smoking among teens and adults and support research on preventing tobacco use, understanding the basic science of the consequences of tobacco use, and improving treatments for tobacco-related illnesses. HHS is striving to reduce adults' annual cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita by 2013.

*Million Hearts Initiative.*—The Million Hearts Initiative is a national public-private initiative aimed at preventing 1 million heart attacks and strokes over 5 years, from 2012 to 2017. It seeks to reduce the number of people who need treatment and improve the quality of treatment that is available. It focuses on increasing the number of Americans who have their high blood pressure and high cholesterol under control, reducing the number of people who smoke, and reducing the average intake of sodium and trans fats. To achieve this overall goal, the initiative will promote medication management and support a network of EHR registries to track blood pressure and cholesterol control, along with many other public-private collaborations. In fiscal year 2013, the budget requests \$5 million for CDC to achieve measurable outcomes in these areas.

*Preventing Teen Pregnancy.*—The budget includes \$105 million for the Office of the Assistant Secretary for Health for teen pregnancy prevention programs. These programs will support community-based efforts to reduce teen pregnancy using evidence-based models and promising programs needing further evaluation. The budget also includes \$15 million in funding for CDC teen pregnancy prevention activities to reduce the number of unintended pregnancies through science-based prevention approaches. Additionally, the budget would repurpose unobligated funds to create a new teen pregnancy prevention program specifically targeted to youth in foster care, who are at particularly high risk of becoming teen parents.

*Protect Vulnerable Populations.*—HHS is committed to ensuring that vulnerable populations continue to receive critical services during this period of economic uncertainty. For example, the Administration for Children and Families (ACF) budget requests includes a \$7 million increase in funding for the Family Violence Prevention programs in order to expand shelter capacity and services and to support higher call volume to the domestic violence hotline.

*Preventing and Treating HIV/AIDS.*—The fiscal year 2013 budget includes \$3.3 billion for domestic HIV/AIDS activities to increase the availability of treatment to people living with HIV/AIDS in the United States, improve adherence to medications, and support prevention programs in States and communities. This total investment includes \$1 billion, an increase of \$67 million, to increase access to life-saving treatments through the AIDS Drug Assistance program, and \$236 million, an increase of \$20 million, to support care provided by HIV clinics across the country.

This total also includes \$826 million for CDC's domestic HIV/AIDS prevention activities, an increase of \$40 million more than fiscal year 2012, to support grants to health departments to reduce new HIV infections, identify previously unrecognized HIV infections, and improve health outcomes. In addition, funds will support research, surveillance, evaluation, and implementation of high-impact prevention programs among HIV-affected populations. In fiscal year 2013, CDC will award grants to 69 State and local health departments to implement HIV/AIDS prevention programs according to a revised funding algorithm instituted in fiscal year 2012, which better aligns the distribution of prevention resources with the disease burden rather than with historical AIDS data. CDC will also support up to 36 jurisdictions for an expanded testing initiative to focus on groups at highest risk for acquiring HIV such as men who have sex with men, African Americans, and injection drug users.

*Refugee Transitional and Medical Services.*—The budget requests \$805 million to provide time-limited cash and medical assistance to newly arrived refugees, helping them become self-sufficient as quickly as possible, and to provide shelter for unaccompanied alien children until they can be placed with relatives or other sponsors, repatriated to their home countries, or receive relief under U.S. immigration law. Additional funding will primarily cover rising medical costs—many refugees have spent their lives in camps where medical care is limited or nonexistent—and serve the growing number of unaccompanied alien children made eligible for benefits under the Trafficking Victims Protection Reauthorization Act of 2008.

*Elder Justice.*—The budget includes \$43 million for the Administration on Aging (AOA) to address the growing problem of elder abuse, neglect, and exploitation which affects more than 5 million seniors annually. Research indicates that older victims of even modest forms of abuse have dramatically higher morbidity and mortality rates than nonabused older people. To combat this abuse, the budget provides \$8 million for newly authorized Adult Protective Services Demonstration grants,

along with \$9 million in ongoing funding for State grants to raise awareness of elder abuse and neglect and for resource centers and related activities that support nationwide elder rights activities. The budget also includes \$17 million for the Long-term Care Ombudsman Program to improve the quality of care for the residents of long-term care facilities by resolving complaints on behalf of residents.

*Keeping People in Communities.*—Part of HHS’ strategic plan includes enabling seniors to remain in their own homes with a high-quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers. Some seniors, if unable to remain independent in the community, will be forced to move into a nursing home at a significant potential cost to Medicaid. The budget includes \$1.4 billion in AOA to help seniors stay in their homes through home and community-based supportive services, senior nutrition programs, and Caregiver Support programs. The budget also proposes to transfer the Senior Community Service Employment program from the Department of Labor (DOL) to the AOA. This move provides greater alignment with the agencies that provide supportive services.

*Community Services Programs.*—The budget includes \$400 million for community services programs. This funding level includes \$350 million for the Community Services Block Grant (CSBG), and proposes to use a system of standards and competition to target the funds to high-performing agencies that are most successful in meeting community needs. In support of the Healthy Food Financing Initiative, \$10 million is available to fund community development corporations to eliminate food deserts by improving access to grocery stores, farmers’ markets, and other venues for healthy, affordable groceries. Additionally, \$20 million is requested for the Community Economic Development program to sponsor enterprises providing employment, training, and business development opportunities for low-income Americans.

*Vulnerable Youth.*—The ACF’s budget includes an additional \$5 million as part of a cross-agency effort to identify and test new ways to strengthen services for disconnected youth—14- to 24-year-olds who are neither working nor in school. This \$5 million will be utilized in close cooperation with an additional \$5 million requested by the Department of Education and \$10 million from DOL. In addition to the funding request, the administration proposes a general provision in the appropriations act to support a limited number of “performance partnerships” that would provide States and localities with enhanced flexibility in determining how services are structured in return for strong accountability for results.

*Reduce Foodborne Illness.*—The budget reflects the administration’s commitment to transforming our Nation’s food safety system into one that is stronger and that reduces foodborne illness and includes an increase of \$17 million above fiscal year 2012 to support CDC’s role in implementing the Food Safety and Modernization Act. HHS will continue to modernize and implement a prevention-focused domestic and import safety system. Collaboratively, the Federal Drug Administrative (FDA) and CDC are working to decrease the rate of Salmonella Enteritidis illness in the population from 2.6 cases per 100,000 to 2.1 cases per 100,000 by December 2013. In fiscal year 2013, CDC will enhance surveillance systems and designate five Integrated Food Safety Centers of Excellence at State health departments.

#### ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

*Biomedical and Behavioral Research.*—The fiscal year 2013 budget maintains funding for the NIH at the fiscal year 2012 level of \$30.9 billion, reflecting the administration’s priority to invest in innovative biomedical and behavioral research that spurs economic growth while advancing medical science to improve health. NIH is generating discoveries that are opening new avenues for disease treatment and prevention and revolutionizing patient care. In fiscal year 2013, NIH will seek to take advantage of such discoveries by investing in basic research on the fundamental causes and mechanisms of disease, accelerating discovery through new technologies, advancing translational sciences, and encouraging new investigators and new ideas.

*National Center for Advancing Translational Sciences (NCATS).*—In fiscal year 2013, NIH will continue to implement NCATS, established in fiscal year 2012, in order to re-engineer the process of translating scientific discoveries into new medical products. Working closely with partners in the regulatory, academic, nonprofit, and private sectors while not duplicating work going on in the private sector, NCATS will strive to identify innovative solutions to overcome hurdles that slow the development of effective treatments and cures. A total of \$639 million is proposed for NCATS in fiscal year 2013, including \$50 million for the Cures Acceleration Network.

*Medical Countermeasure Development.*—The HHS Medical Countermeasure Enterprise includes initiatives across the Department covering the spectrum of medical countermeasure development, from early biological research to stockpiling of approved products. The fiscal year 2013 budget includes \$547 million for the Biomedical Advanced Research and Development Authority, an increase of \$132 million more than fiscal year 2012, to develop and improve next-generation medical countermeasures (MCM) in response to potential chemical, biological, radiological, and nuclear threats. The budget also provides \$50 million to establish a strategic investment corporation that would function as a public-private venture capital fund providing companies developing MCMs with the necessary financial capital and business acumen to improve the chances of successful development of new MCM technologies and products. Together, these investments will provide HHS with new tools to enhance the success of medical countermeasure development.

*Enhancing Healthcare Decisionmaking.*—The HHS budget includes \$599 million for research that compares the risk, benefits, and effectiveness of different medical treatments and strategies, including healthcare delivery, medical devices, and drugs, including \$78 million from the Patient-Centered Outcomes Research Trust Fund (PCORTF) established by the ACA. Evidence generated through this research is intended to help patients make informed healthcare decisions that best meet their needs. This level of funding will primarily support research conducted by NIH, core research activities within the Agency for Healthcare Research and Quality, and data capacity activities within the Office of the Assistant Secretary. Resources from PCORTF will support comparative clinical effectiveness research dissemination, improved research infrastructure, and training of patient-centered outcomes researchers. HHS core research will be coordinated to complement projects supported through PCORTF and through the independent Patient-Centered Outcomes Research Institute.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORK FORCE

*Investing in Infrastructure.*—A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The budget includes \$677 million, an increase of \$49 million more than fiscal year 2012, within Health Resources and Services Administration (HRSA) to expand the capacity and improve the training and distribution of primary care, dental, and pediatric health providers. The budget will support the placement of more than 7,100 primary care providers in underserved areas and begin investments that expand the capacity of institutions to train 2,800 additional primary care providers more than 5 years.

The fiscal year 2013 budget also supports State and local capacity for core public health functions. Within the Prevention Fund allocation, CDC will invest \$20 million in new activities to coordinate with public health laboratories to improve efficiency through proven models, such as regionalizing testing in multi-State laboratories. To ensure an effective public health workforce, the budget requests \$61 million, of which \$25 million is through the Prevention Fund, for the CDC public health workforce to increase the number of trained public health professionals in the field. CDC's experiential fellowships and training programs create a prepared and sustainable health workforce to meet emerging public health challenges. In addition, the budget requests \$40 million in the Prevention Fund to maintain support for CDC's Public Health Infrastructure program. This program will assist health departments in meeting national public health standards and will increase the capacity and ability of health departments in areas such as information technology and data systems, workforce training, and regulation and policy development.

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILITY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS

*Living Within Our Means.*—HHS is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. The fiscal year 2013 discretionary request demonstrates this commitment by maintaining ongoing investments in areas most central to advancing the HHS mission while making reductions to lower-priority areas, reducing duplication, and increasing administrative efficiencies. Overall, the fiscal year 2013 request includes more than \$2.1 billion in terminations and reductions to fund initiatives while achieving savings in a constrained fiscal environment. Many of these reductions, such as the \$177 million cut to the Children's Hospital Graduate Medical Education Payment program, the \$327 million cut to CSBG, and the \$452 million cut to the Low Income Home Energy Assistance Program (LIHEAP) were very difficult to make but are necessitated by the current fiscal environment.

Regarding LIHEAP, the administration proposes to adjust funding for expected winter fuel costs and to target funds to those most in need. The request is \$3 billion, \$452 million below the fiscal year 2012 level and \$450 million more than both fiscal year 2008 and fiscal year 2012 request. With constrained resources, the budget targets assistance where it is needed most. The request targets \$2.8 billion in base grants using the State allocation the Congress enacted for fiscal year 2012. The request also includes \$200 million in contingency funds, which will be used to address the needs of households reliant on home delivered fuels (heating oil and propane) should expected price trends be realized, as well as other energy-related emergencies.

In September 2011, the administration detailed a plan for economic growth and deficit reduction. The fiscal year 2013 budget follows this blueprint in its legislative proposals, presenting a package of health savings proposals that would save more than \$360 billion more than 10 years, with almost all of these savings coming from Medicare and Medicaid. Medicare proposals would encourage high-quality, efficient care, increase the availability of generic drugs and biologics, and implement structural reforms to encourage beneficiaries to seek value in their healthcare choices. The budget also seeks to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the fiscal year 2013 discretionary budget request and these legislative proposals allow HHS to support the administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

*Program Integrity and Oversight.*—The fiscal year 2013 budget continues to make program integrity a top priority. The budget includes \$610 million in discretionary funding for Health Care Fraud and Abuse Control (HCFAC), the full amount authorized under the Budget Control Act of 2011 (BCA). The budget also proposes to fully fund discretionary program integrity initiatives at \$581 million in fiscal year 2012, consistent with the BCA. The discretionary investment supports the continued reduction of the Medicare fee-for-service improper payment rate; investments in prevention-focused, data-driven initiatives like predictive modeling; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives, including Medicare Strike Force teams and fighting pharmaceutical fraud.

From 1997 to 2011, HCFAC programs have returned more than \$20.6 billion to the Medicare Trust Funds, and the current 3-year return-on-investment of \$7.2 recovered for every \$1 appropriated is the highest in the history of the HCFAC program. Last year these efforts recovered more than \$4 billion. The budget proposes a 10-year discretionary investment yielding a conservative estimate of \$11.3 billion in Medicare and Medicaid savings and 16 program integrity proposals to build on the ACA's comprehensive fraud fighting authorities for savings of an additional \$3.6 billion over 10 years.

Additionally, the budget includes funding increases for significant oversight activities. The request includes \$84 million for the Office of Medicare Hearings and Appeals, an increase of \$12 million, to continue to process the increasing number of administrative law judge appeals within the statutory 90-day timeframe while maintaining the quality and accuracy of its decisions. The budget also includes \$370 million in discretionary and mandatory funding for the Office of Inspector General (OIG), a 4-percent increase from fiscal year 2012. This increase will enable OIG to expand CMS Program Integrity efforts in areas such as HEAT, improper payments, and focus on investigative efforts on civil fraud, oversight of grants, and the operation of new ACA programs.

Additionally, Durable Medical Equipment (DME) Competitive Bidding is providing competitive pricing, while continuing to ensure access to quality medical equipment from accredited suppliers, which will save Medicare \$25.7 billion over 10 years and help millions of Medicare beneficiaries save \$17.1 billion in out-of-pocket costs over 10 years. The budget proposes to extend some of the efficiencies of DME Competitive Bidding to Medicaid by limiting Federal reimbursement on certain DME services to what Medicare would have paid in the same State for the same services. This proposal is expected to save Medicaid \$3 billion over 10 years.

*Consolidate and Improve Activities Related to Prevention and Behavioral Health.*—The budget includes \$500 million within SAMHSA for new, expanded, and refocused substance abuse prevention and mental health promotion grants to States and tribes. To maximize the efficiency and effectiveness of its resources, SAMHSA will use competitive grants to identify and test innovative prevention practices and will leverage State and tribal investments to foster widespread implementation of evidence-based prevention strategies.

The budget also consolidates funding for initiatives aimed at addressing chronic disease prevention. Chronic diseases and injuries represent the major causes of mor-

bidity, disability, and premature death and heavily contribute to the growth in healthcare costs. The budget aims to improve the health of individuals by focusing on prevention of chronic diseases and injuries rather than focusing solely on treating conditions that could have been prevented. Specifically, the budget allocates \$379 million, an increase of \$129 million more than fiscal year 2012, to a new integrated grant program in CDC that refocuses disease-specific grants into a comprehensive program that will enable health departments to implement the most effective strategies to address these leading causes of death. Because many inter-related chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the burden of chronic disease.

Senator HARKIN. Thank you very much, Madam Secretary.

Madam Secretary, I am going to yield my opening position to Senator Mikulski who has to go chair another hearing here very shortly.

#### STATEMENT OF SENATOR BARBARA A. MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman, for yielding.

Senator Inouye is indisposed this morning and I am going to chair the Department of Defense appropriations hearing. So it is really the day of shooting straight.

I am only 4 foot 11, so you cannot see me, but you have certainly been able to hear me.

Secretary SEBELIUS. I can see you.

#### IMPROVING HEALTHCARE QUALITY

Senator MIKULSKI. Let me get right to my question, Madam Secretary.

I want to thank you for the great job you are doing. I want to thank you for your respect of implementing the laws that the Congress passes, your respect for the Constitution and all of its amendments, and also creating the sense of your agencies working with the Congress. My work with Dr. Margaret Hamburg on the Prescription Drug User Fee Act (PDUFA), the way she has reached out in her agency to the business community has really been I think a model of how to work to keep our people safe and yet to not shackle them with unnecessary regulation.

Let me get to my question on quality. When we worked on ACA, Senator Harkin, of course, was one of the leaders on the bill and on prevention. I worked with him on that. And I worked on the quality initiatives. The goal was two things: one, not only to improve access, but by improving quality, we could save lives and save money. We have the home of Dr. Pronovost at Hopkins, the famous Pronovost checklist.

My question to you is, "How are we training the cadre of scientists and physicians in the area of quality medical delivery services?" I have been advised by the School of Public Health and Dr. Pronovost himself that there is this whole body of knowledge that could be taught at great schools of medicine and public health where it would not be just a few leaders like Pronovost, but we would be training people in the science of healthcare delivery and developing it so they would be in communities, they would become hospital administrators, et cetera. Would you look at all of your programs to see how we could encourage that?

Secretary SEBELIUS. I would be delighted to work with you on that, Senator Mikulski.

I can tell you that what is happening now is very exciting for the next generation of providers and administrators because I think for the first time across this country, there is a focus and highlight on real changes, transformations in the delivery system, and a lot of that is focused on taking the best practices which exist in pockets—and certainly the checklist is a great example of that—but bringing them to scale and having every health system in the country adopt some of these practices in a much more timely fashion. So through our Innovation Center and through the Partnership for Patients, which now has engaged more than 5,000 partners, private employers, payers, and hospital systems, we are actually capturing the quality programs and—

Senator MIKULSKI. But you are going to need people to do this.

Secretary SEBELIUS. You bet.

Senator MIKULSKI. And just as we have skilled surgeons, those who do the hands-on medicine, for those to advise those in the practice of medicine, hospital administrators, Governors looking at how to handle an increasing, burgeoning Medicaid costs. So would you look at that and respond to me?

Secretary SEBELIUS. Yes, I would.

#### CHILD CARE QUALITY INITIATIVES

Senator MIKULSKI. My second and last question will be child care quality initiatives. I chair the subcommittee on Children and Families. We have had extensive hearings on reauthorizing the Child Care Development Block Grant. We have bipartisan cooperation. I cannot say enough about Senator Burr's work, how we are working together.

My question goes, as we look forward to access, there is also child safety and child quality. There has been a recent story on "Nightline" that our current laws are inadequate in terms of background checks and so on. So we want to increase access, keep it affordable. But my God, when you go to a day care center, you have got to make sure that the people who are the day care providers, number one that it is a safe environment and also their education and training. Could you comment? Have you seen the "Dateline" story?

Secretary SEBELIUS. I have not seen the "Dateline" story, but I have read the clips about it.

Senator MIKULSKI. You know what I mean.

Secretary SEBELIUS. Absolutely.

Senator MIKULSKI. I know of your work as Governor and child advocate, do you have any comments or would you like to respond in writing because we hope to reauthorize this program, and we are looking to advice and guidance from the Department.

Secretary SEBELIUS. Well, we very much are eager to work with you, and I think you have articulated very well the principles around which we think reauthorization should occur, not only making sure that there are additional slots for families, knowing that child care is really one of the work-friendly programs—you cannot go to work if your children are not in a safe and secure place—but also knowing that way too many parents either do not have a way

to understand what is going on in the system and do not have the confidence that any place they put their child is a high-quality care system. So improving quality and getting that information into the hands of parents, sort of the rating system, so parents really can make the best choice for themselves and their children is an effort that is underway, as you know, and we think has to be part of the framework for reauthorization.

Senator MIKULSKI. Madam Secretary, my time is up, and Senator Harkin has been gracious. What we are looking at is how we can improve that background check without adding more cost and more regulation and, second, really how we get to the training of these child care workers and how they have perhaps a career ladder like we have done in nursing, CNA, licensed practical nurse, so they see a career.

Secretary SEBELIUS. And, Senator, just so you know a little bit about my history, I went to the legislature in Kansas when my children were 2 and 5, and this became an issue that was near and dear to my heart and has been ever since. That was a very long time ago, but child care was something I was living at the time, so it became one of my causes. And I very much look forward to working with you.

Senator HARKIN. Thank you, Senator Mikulski.

Thank you, Madam Secretary.

Senator Shelby.

#### NIH FUNDING

Senator SHELBY. Thank you.

Madam Secretary, the 2013 budget proposal, with the Public Health Service Act evaluation tap increase included, reduces NIH's budget by \$215 million below fiscal year 2012. How will NIH maintain its scientific rigor and innovation when the budget request does not keep pace with the biomedical inflation rate? Do we not have a problem here?

Secretary SEBELIUS. Well, Senator, I first of all share your belief that continuing to make sure that America leads the world in biomedical research is a critical priority for the future, and we look forward to working with the Congress around the tap issue as we move forward.

Having said that, I can tell you that Dr. Collins has allocated resources within NIH's budget, which is currently funded at the level that it was funded last year, and made sure that we continue to fund new grants. His report is that the fiscal year 2013 budget level will allow him to increase the grants by about 7.7 percent. An additional 672 new grants will be funded. He is also very appreciative of the notion that working with the Congress, the National Center for Translational Sciences was funded, and he is moving ahead on that. There are new resources where he feels is an enormously promising area to recapture and refocus some of the energy, as well as the Cures Acceleration Network has additional resources. So this budget not only reflects our desire to make sure that we continue to fund new scientific discoveries but also to focus the resources on the areas that are the most promising strategies for the future.

## HEALTH INSURANCE EXCHANGES

Senator SHELBY. In another area, the fiscal year 2013 budget proposal includes \$864 million for the implementation of the new health insurance exchanges. HHS has already received \$1 billion in ACA for the implementation activities and will receive a little more than \$1 billion more in mandatory funding for the exchange in 2013. Why is it necessary to appropriate an additional \$864 million for exchanges?

Secretary SEBELIUS. Senator, the request before this subcommittee for the additional resources for the Centers for Medicare & Medicaid Services (CMS) reflects the fact that we anticipate that the first \$1 billion funding that was included in ACA in 2010 will be fully spent by the end of fiscal year 2012. The good news is we are spending significantly under what was estimated by the Congressional Budget Office (CBO) which estimated, at the time of passage, that we would need about \$1 billion a year to implement this. So here we are looking at the end of 2012, and the first \$1 billion will be spent in the 2½ years since implementation.

What we are requesting with the \$800 million for new resources is basically a one-time cost to build the framework for the Federal exchange which will be run out of CMS. We are not clear at this point how many States will actually opt to run their own State-based exchanges, how many States will be in a so-called partnership where the Federal exchange will run part of the program and they will run part and how many will fully run. But we need an infrastructure, an IT system, an outreach system, an enrollment system. So this is the request for 2013 which again is not an ongoing request, but it is basically to build that framework for the federally funded exchanges.

## ANTIDEFICIENCY ACT VIOLATIONS

Senator SHELBY. Madam Secretary, in the area of Antideficiency Act violations, a lot of us are concerned about the series of Antideficiency Act violations by your Department and the lack of a corrective action to address these unlawful funding practices.

Last July, you notified us that the Department had 47 violations that amounted to more than \$1.4 billion in illegal funding practices. At a time when the Department is receiving a historically high level of funding, I believe it is critical that you follow the letter of the law here.

Clearly, there are significant weaknesses over there. Are you following the recommendations of the Office of Inspector General (OIG), or are you trying to just ignore those past violations and move to a clean slate? What is going on?

Secretary SEBELIUS. Well, Senator, as we notified the committees in July, we were made aware that there were 47 contracts that were improperly funded dating back to 2002. I would say the positive news about that is that the contracts were not structured properly according to the Antideficiency Act, but the monies were all appropriately spent. They were not overspent.

Having said that, we took this violation very seriously. We self-reported it. We have engaged in a really robust activity at the Department working with the OIG, as well as working with GAO, on

everything from changing policies and procedures. We have trained 12,000 staff members on how this has to be done. We have gone back through the corrections and we would be delighted to give you in writing the full report on what has occurred so far and how seriously we take this. We do take it very, very seriously.

Senator SHELBY. Thank you.

#### IMPACT OF SEQUESTRATION

Senator HARKIN. Thank you, Senator Shelby.

Here is the order I have. I will ask the next round of questions for 5 minutes and then Senators Alexander, Brown, Johnson, Landrieu, Moran, Kohl, and Graham will speak.

Madam Secretary, next January we are facing a possible sequestration to reduce the national debt. I applaud the President for presenting a fair and responsible budget to help avert this outcome except in the areas I noted in my opening statement. It is critical for this subcommittee to understand the potential impact of this possible sequestration. CBO estimated that most non-defense discretionary programs would face a cut of up to 7.8 percent. Others, such as the Center on Budget and Policy Priorities, think the cut could be even larger. But for the sake of discussion, we will go with CBO's number of 7.8 percent.

My question. Have you looked at this? Could you give us some idea of what would be the impact of a 7.8-percent cut to programs like Head Start, the Child Care and Development Block Grant that you and Senator Mikulski were discussing, AIDS Drug Assistance Program, senior nutrition, all the other areas? What would be the impact of that 7.8-percent cut?

Secretary SEBELIUS. Well, Mr. Chairman, as you well know, within our Department the application of sequestration becomes even more complicated. We have some programs that would be fully shielded from any cuts. We have some programs which are limited to a 2-percent cut, which means that there would be an even harsher application of sequestration across the board on our programs.

So we think if it were a close to 8-percent cut, we would lose about 1 million slots in both Head Start and Child Care. I am sorry. Not 1 million. One hundred thousand slots in Head Start and Child Care. About 75,000 children would lose their places in Head Start and about 25,000 in Child Care.

We have about 17 million meals that would not be delivered to seniors relying on congregate meals and home delivery.

The AIDS Drug Assistance program would have to reduce its caseload by more than 12,000 people who are currently receiving antiretroviral drugs.

And the NIH budget, which I know is a concern to members of this subcommittee, would lose about \$2.5 billion. NIH is 40 percent of our budget. They would take a huge hit, and we think that research project grants would decline by—about 2,300 grants would be discontinued. More than one-quarter of the number estimated for fiscal year 2012 would be gone, and that would be about one-third of a reduction. One-third of the programs that we are estimating for fiscal year 2013 would cease to exist.

So it would have a huge impact across our Department and particularly for the areas that are not shielded and therefore would take an even more significant hit.

Senator HARKIN. Well, thank you, Madam Secretary. I am going to be asking that same question when the Secretaries of Labor and Education and the NIH Director are up here also. We have heard a lot from the defense community about what would happen to their portion of national security if they had a 7.8-percent cut. I think it is important for the American people to know about the rest of our national security because as President Truman once said so eloquently so many years ago, he said our national security is not measured just in tanks and guns alone but also in the health, welfare, and education of our people.

Secretary SEBELIUS. And as you know, these programs affect real people every day and are often life and death issues.

#### HEALTHCARE FRAUD, WASTE, AND ABUSE

Senator HARKIN. Exactly. Well, thank you.

Last, could you address the fraud and waste issue that I mentioned in my opening statement? We had that Budget Control Act cap adjustment that allowed a \$270 million increase, but when we got to conference, my friends on the other side of the aisle said no, and so we did not get that. What does that mean in terms of not returning money to the taxpayers?

Secretary SEBELIUS. Well, over the last 3 years, as I said, Mr. Chairman, we have been able to return about \$7 for every \$1 invested. So a \$270 million cut is significant. We know that our OIG had plans for the use of those resources to further expand some of our footprint on the ground to new strike forces in new cities, and those will have to be on hold. And we would love to work with you in a full funding for this program, which I think is an absolute win-win situation to stop people from stealing health dollars, taxpayer dollars, to continue to build our data analytic system so that we can do far more prevention on the front end and to have the boots on the ground to go after the perpetrators who we think are committing these outrageous acts of fraud and stop them quickly on the ground.

Senator HARKIN. Thank you, Madam Secretary.  
Senator Alexander.

#### MEDICAID

Senator ALEXANDER. Thanks, Madam Secretary. Welcome. Thank you for coming.

I have just two preliminary comments and then a question.

Senator Mikulski mentioned Prescription Drug User Fee Act (PDUFA), and I wondered if we could not pause for a moment of bipartisan cooperation. We have four authorizing laws that establish fees for prescription drugs, medical devices, biosimilar drugs, and generic drugs, and we call them PDUFA, Medical Device User Fee Act, Biosimilar User Fee Act, and Generic Drug User Fee Act. And I wonder if we could have a prize for an elegant replacement for all of those ridiculous names that we just throw around up here.

Secretary SEBELIUS. I have to say it took me most of the last 3 years to learn what people were even talking about when they would mention those to me. So I am all for it.

Senator ALEXANDER. Good. Well, I will work with the chairman and we will see what we can do about that.

I wanted to mention simply to you—and I will write you a letter about this—the Tennessee Poison Control Center. It is a very small program located at Vanderbilt University, but when kids get in trouble at home, they can telephone this poison control center and the parent gets talked through what to do about it rather than their going to the emergency room. It is 80 percent paid for by State and local funding. The Federal Government has a share of it. It saves about \$11 million a year, people think, in emergency room costs. And I just wanted to call it to your attention and you do not need to respond to it now. But I think it is worth noting the importance of it.

I wanted to just ask you a question in sort of a Governor-to-Governor way. You were a Governor. I was a Governor. We have these wistful—or at least I do—thoughts of those days as if they were trouble-free and everything was great, which is not exactly true, but it was a wonderful experience.

And I am worried that the new healthcare law has created a situation where we are 1 budget year away from a ticking time bomb in the States for Governors as they seek to comply with the Federal requirements for expansion of Medicaid and then Federal requirements for paying doctors who want to serve people who get Medicaid. I know our former Governor, a Democrat, Governor Bredesen, called that the mother of all unfunded mandates. He estimated that it will cost Tennessee an additional \$1.1 billion between 2014 and 2019. The Federal Government helps with that for a while, but then it is fully a State responsibility.

And then we add to that by a Federal requirement that doctors be reimbursed, providers be reimbursed for seeing Medicaid patients, which needs to happen otherwise it is a ticket to a bus that does not run. So people need to be able to see a doctor. But that adds another \$324 million a year to our State. And we are already in a situation where rising healthcare costs are squeezing money out of our State budgets that otherwise would be spent for higher education.

Now, this is not something new with President Obama. This has been going on for 30 years. I used to deal with it in Tennessee almost every year. I imagine you dealt with it as Governor of Kansas. You get down to the end of the budget process and you have got money either for Medicaid or the University of Kansas, the University of Tennessee, and it is a very difficult choice. And the healthcare costs keep going like this. And as a result in Tennessee last year, there was a 16-percent increase in State Medicaid spending, a 15-percent decrease in State support for higher education. That is not a Washington cut. That is a real cut. And so tuition goes up at the universities and quality goes down.

So as I said, this is not new. I first suggested to President Reagan a long time ago that we have a swap, that the Federal Government take all the Medicaid and the States take all of elementary and secondary education. Former Senator Kassebaum from

Kansas came up with a similar idea in the 1980s because of this combination of Federal controls and State spending.

Do we not have to do something to give States more flexibility in dealing with Federal Medicaid mandates in order to avoid exporting fiscal instability from Washington to State capitals that has the primary effect of squeezing down the quality of public higher education and raising tuition for the students who go there? And if that is a problem and it is going to start in the next budget year, 2014, can you suggest anything that we could do to make it easier?

Secretary SEBELIUS. Well, Senator, I did deal as you did with these budget challenges at the State level, and I have dealt actively since I came to this position with my colleagues around the country who are coping with this.

I will provide you in writing with some of this analysis, but just to give you a little snapshot. At least in the last 3 years, State share of spending on Medicaid is actually reduced nationally. Their overall budget share that they were spending on Medicaid in 2007 was higher than it was in 2010, which is the last full year that we have. Per capita costs for Medicaid have dropped in that period of time. They were above \$2,200 a person. They are now down below \$1,800 a person for the Medicaid budgets on average. And the overall State expenditures have dropped during that period of time. Some of that was clearly helped by the Federal resources that were put in as part of the American Recovery and Reinvestment Act, but the State picture is actually different.

The final thing that I asked our folks to do in terms of just analysis is look at underlying healthcare costs, which are continuing to rise, compared to higher education costs. And actually higher education costs are now up 63 percent in the last decade. And healthcare spending is up about 40 percent. So you are absolutely right. This is an ongoing challenge. It is one that people are coping with.

I would tell you that the Medicaid expansion that is on the horizon for 2014 is some pretty good news for States, and it is not only fully paid for by the Federal Government for the first 4 years, but the Federal share stays for the newly insured population between 100 and at the lowest 90 percent by the time the decade ends, so that the largest share that the State will pay in that period of time for millions of newly insured folks is a 10 percent match.

Having said that, States now absorb enormous amounts of costs for uncompensated care where people are coming into community hospitals, are in the workforce, and States are paying a share of that cost out of taxpayer dollars. So on balance, I think this is an opportunity to not only have a payment system under a lot of folks, get them in a healthier condition, but also I think States—ironically those who have the lowest-insured population are the biggest winners in some ways that have had not very generous Medicaid systems and have the most people that will actually become fully insured as part of this program.

We are also paying careful attention to the provider issue. As you say, there is a requirement that doctors who take care of Medicaid patients will be paid at the Medicare rate for the first 2 years fully out of Federal dollars. It is not a State mandate. It is fully out of Federal dollars. We know that it is not a long-term strategy. We

look forward to working with the Congress on a long-term strategy, but again, there is no mandate beyond those 2 years and there is no mandated State funding beyond those 2 years.

Senator ALEXANDER. Mr. Chairman, I am out of time and I would welcome that information.

Secretary SEBELIUS. I would be happy to provide it.

[The information follows:]

Medicaid spending in 2010 was estimated to be approximately 15.8 percent of State general fund spending but was 17.4 percent in 2006.

Numerous experts agree that States will actually realize a net savings from the provisions of the Affordable Care Act. States and local governments are estimated to save \$70–80 billion in State-funded health coverage or uncompensated care. A subsequent Urban Institute analysis estimates that the costs to States from the Medicaid expansion will be more than fully offset by other effects of the legislation, for net savings to States of \$92 to \$129 billion from 2014 to 2019.

Senator ALEXANDER. Nevertheless, our former Governor says these mandates are \$1.2 billion over 5 years in increased costs just for the expansion and \$324 million a year for the Medicaid reimbursement requirement.

Senator HARKIN. Thank you.

Senator Brown.

#### PRIMARY CARE WORKFORCE

Senator BROWN. Thank you, Mr. Chairman.

I note from the Secretary's comments that in those States where there was not a lot of support, at least from their elected officials, for ACA, those are the ones, because they are the poorer States, that tend to get the most. It is an interesting irony.

First of all, thank you, Madam Secretary. Thank you for last week for coming to Ohio, and the support you have shown for Project One really means a lot for my State. Thank you for that.

Thank you too for what you did, what CMS did, and what Federal Drug Administration (FDA) did on the progesterone issue, that pharmaceutical, the P7 to 17P, the progesterone that saved a huge—that have prevented a huge number of preterm births, resulted in tens and tens of thousands of babies born healthy instead of born with all kinds of illnesses and disabilities. And the work that you did, stepping up, having the FDA telling local compounders and local doctors and hospitals not to—to resist the cease and desist order and then the work that Mr. Berwick did at CMS in encouraging—in going to the States so that more and more States are using the progesterone at much less cost to taxpayers and to insurers than they are the KV Pharmaceuticals Makena. It has made a huge difference in public health.

I want to talk about a couple other programs that are involved in preterm birth rates. The Community Health Access Program in Mansfield, my hometown, trains community health workers to address the health needs of at-risk pregnant women, low-income White and African-American women in two different ZIP codes, and Richland County sort of invented this program. The local officials did, local doctors, local foundations, and dropped the low-birth-weight baby rate from twice the national average to below the national average. And using that program, the Community Health Access program, as a model, we added the community health work-

ers to the list of disciplines on which area health education centers should focus. I mean, that was the good news.

Also, the good news is the program of the maternal, infant, and early childhood home visiting program which has made a huge difference in after the babies are born, making sure they get the proper services—well, starting with prenatal care up through early education for children. Now, that is the good news.

The good news also is that the budget includes \$400 million for the maternal and infant home visiting programs. The bad news is that health education centers are zeroed out in this year's budget, funded at \$27 million in fiscal year 2012. It means increasing shortages of primary care providers especially in those rural and underserved areas.

My question is what will happen to the number of primary care workers if these programs are eliminated. How do we make up for this? I mean, it clearly saves large amounts of money when people get to the doctor, get proper nutrition, get prenatal care the way they should and babies are born healthy instead of born with all kinds of illness and disabilities. What is going to happen to the number of primary care workers? What do we do about this with these cuts?

Secretary SEBELIUS. Well, Senator, we are trying to focus as many resources throughout the Department as we have on increasing the primary care workforce, and that is everything from shifting graduate medical education slots to new funding for the National Health Service Corps for primary care providers has been tripled in the last 3 years, and we want to continue that effort. We are looking at all the strategies that we have, payment rates to encourage primary care choices for medical students, and a series of activities. So we certainly share your concern around that.

I know that you and I have talked before about your Mansfield, Ohio success program, and I wanted to bring to your attention that we have recently launched an initiative we are calling Strong Start under the Center for Medicare and Medicaid Innovation that will be working with the March of Dimes, with the American College of Ob-Gyns, with providers across this country around a focus on births that occur 39 weeks and beyond, knowing that there is a huge health difference between preterm babies and post-term babies and that appropriate prenatal care, maternal information, encouraging hospitals to reduce the number of voluntary preterm deliveries that they are willing to engage in and adopting some of the best practices that you have in Ohio. I would love to get you some information about this program because actually there may be some ways to take what you have learned in Mansfield and make sure that we can not only spread it in Ohio but in various other parts of the country. But it is an initiative we think is not only hugely important to reduce long-term health costs, but good for moms, good for babies, good for the long-term community survival. So we are really looking at how to bring this program to scale throughout the country.

Senator BROWN. Thank you.

Mr. Chairman, I will only make a comment, if I could, not another question. A comment.

First of all, thank you for that. The Mansfield program has already spread to a couple other Ohio cities.

I will make one comment about—you had mentioned Graduate Medical Education (GME) slots. A subset of that—and this is not a question, just a comment, if you would—is children’s GME. Every administration in both parties cuts back this program after we began it. I first introduced it in the House in 1998, I think, after a visit to Akron Children’s Hospital. We need a unique way, a separate way of funding graduate medical education for children because it does not fit in, obviously, the Medicare funding stream that creates money for GME. Every year a President cuts it or eliminates it. We need to get it back up at least to the level of \$250 or \$300 million, which it has been many of the last few years. Chairman Harkin has been very helpful to that in the past. Many of my Republican colleagues too. It was a very bipartisan effort in the House when I first started it. And we will figure out a way to do that. I know you do not oppose it, but I know you know that we will restore it and come up with the money. And I appreciate that shift of responsibility every year.

But thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Brown.

Senator JOHNSON.

#### HEALTHCARE COST ESTIMATES

Senator JOHNSON. Thanks, Mr. Chairman.

Madam Secretary, welcome.

I would like to concentrate on the cost estimates of the healthcare law because that is what I was concentrating on last year and there has certainly been new information to surface since then.

So I would like to first start out by just pointing out that when they passed Medicare back in 1965, they estimated it out 25 years and said it would cost \$12 billion in 1990. In fact, it ended up costing \$109 billion, nine times the original cost estimate. So I do not have a great deal of faith in some of these estimated numbers, and I certainly do not have faith in the estimates for Obamacare.

In the President’s fiscal year 2013 budget just released, he has increased the mandatory outlays for health insurance exchanges by \$111 billion from \$367 billion in his last year’s budget to \$478 billion. Is that correct?

Secretary SEBELIUS. Yes, Sir.

Senator JOHNSON. The Community Living Assistance Services and Support program (CLASS Act)—I think we end up recognizing that that was not going to work out. That was not going to be financially solvent. So that was \$86 billion of the claimed \$143 billion of deficit reduction in the first 10 years. Correct?

Secretary SEBELIUS. The original estimate, yes.

Senator JOHNSON. Right. And the original estimate for deficit reduction in the first 10 years was \$143 billion. Correct?

Secretary SEBELIUS. Yes.

Senator JOHNSON. So now we have reduced that \$143 billion by \$86 billion by not getting revenue from the CLASS Act and now \$111 billion because we have increased the mandatory cost of the exchanges. Correct?

Secretary SEBELIUS. I am assuming the numbers are correct. I am sorry. I do not have them.

Senator JOHNSON. They are.

So when you add those together, that is \$197 billion added to the first 10-year cost estimate of Obamacare. So now we are, instead of saving \$143 billion, adding \$54 billion to our deficit. Correct?

Secretary SEBELIUS. Sir—

Senator JOHNSON. We will submit that for the record. That is basically true. So instead of saving \$143 billion by this administration's own figures and budget, we are now adding \$54 billion to our deficit in the first 10 years. To me that would be the first broken promise.

It is true that the President said that by enacting this healthcare law, every family would save \$2,500 per year in their family insurance plan. Correct?

Secretary SEBELIUS. He said that once the exchanges are up and running and you have an affordable marketplace, the insurance estimates were that the rates would go down by about \$2,500, yes. That has not occurred yet clearly.

Senator JOHNSON. The Kaiser Family Foundation has already released a study saying that the average cost for family healthcare plans is up \$2,200. Correct?

Secretary SEBELIUS. Again, there is no new marketplace yet for insurance policies.

Senator JOHNSON. But the cost is already up. I mean, we are already different by \$4,700. It is going to be hard to get us down to \$2,500 as cost savings. I would consider that broken promise number two.

It is also true that President Obama very famously said, "If you like your doctor, you will be able to keep your doctor. Period. If you like your healthcare plan, you will be able to keep your healthcare plan. Period." No one will take it away no matter what.

Now, we have granted quite a few waivers, about 1,200 to 1,700 waivers on about 4 million Americans. Correct?

Secretary SEBELIUS. I have no idea what waivers you are talking about.

Senator JOHNSON. Those are waivers—

Secretary SEBELIUS. Doctors and health plans? Is that—

Senator JOHNSON. Just waivers from having to implement portions of the healthcare law that probably would have forced those workers off their employer-sponsored care.

Secretary SEBELIUS. Again, I would be happy to answer these questions, but I have no idea what waivers you are talking about.

Senator JOHNSON. The waivers that HHS has granted to employers.

Secretary SEBELIUS. To do what?

Senator JOHNSON. Not having to implement sections of the healthcare law.

Secretary SEBELIUS. There have been waivers granted to employers, yes.

Senator JOHNSON. And had those waivers not been granted, chances are those employees probably would have lost their employer-sponsored care. Correct?

Secretary SEBELIUS. I have no idea. I mean, I am happy to answer those one at a time and look at the waivers and see what—

Senator JOHNSON. Unfortunately, I am pretty short on time.

The CBO alone estimated that 1 million people would lose their employer-sponsored care. Now, I think that is a wildly underestimated figure. The McKinsey Group has surveyed employers and said that 30 to 50 percent of employers plan on dropping coverage as soon as the healthcare law is implemented. Douglas Elmendorf I think has even admitted that that is credible evidence for him to retake a look at that estimate.

The decision an employer is going to have is pretty linear. They can pay \$15,000 for a family plan or pay the \$2,000 penalty, and they are not exposing their employees to financial risk. They are making them eligible for \$10,000 subsidies if they make a \$64,000 household income.

Are you sure that only 1 million people—only 1 million people—will lose their employer-sponsored care? Last year you said there are 180 million to get coverage through their exchanges. Are you certain that only 1 million people are at risk of losing their employer-sponsored care and get put in those exchanges?

Secretary SEBELIUS. Sir, you are quoting a CBO number. All we have to go on is what has happened in Massachusetts where actually more people have coverage today with the exchange, with a very similar framework, than did before. They have not lost employer coverage. More employers have come back into the market. So the practical application of a State-based exchange on the ground with similar penalties and a similar framework is employer coverage rose. It did not decrease.

Senator JOHNSON. It is not similar because those employees lose coverage for 6 months before they are eligible for the exchanges, and there are not these types of subsidies that create a huge incentive for employers to drop coverage and make their employees eligible.

Bottom line here. The cost of this healthcare law is so uncertain. Do you not think we maybe ought to put the brakes on it? You know, Nancy Pelosi said we have to pass this law to figure out what is in it. What I do not want to see is we have to implement it to figure how it is going to bust a hole in our already horribly broken budget.

Secretary SEBELIUS. Well, I would just say, Senator, the statistics you gave on the rising healthcare costs for families and small business owners that Kaiser put out recently is the very reason that we desperately need a new insurance market. The private insurance market is basically on a death spiral where younger and healthier people are dropping out, where small employers who cannot afford to pay 18 percent more than their large employers are dropping out.

Doing nothing is really not an option. We now have 50 million uninsured in this country, and that number has gone up year in and year out, and the costs continue to rise. So a new market with competition putting people in a larger pool, making companies compete on the basis of price and quality, not who can lock out folks with a pre-existing condition or drop them out or drive them out of the market is desperately needed by millions and millions of

Americans, which was part of the driving force of passing the healthcare law.

Senator JOHNSON. Madam Secretary, if 50 percent of employees lose their coverage, that will cost us \$500 billion a year, not \$95 billion.

Thank you, Mr. Chairman.  
 Senator HARKIN. Thank you.  
 Senator Kohl.

#### PHYSICIAN PAYMENTS

Senator KOHL. Thank you, Mr. Chairman.

Madam Secretary, I would like to ask you about implementation of the Physician Payments Sunshine Act which, as you know, is a law that I worked on with Senator Grassley. The Physician Payments Sunshine Act requires transparency that will help prevent conflicts of interest, while at the same time highlighting the legitimate and necessary relationships between doctors and industry.

In my State of Wisconsin, the Milwaukee Journal Sentinel wrote a series of reports on problems that arise when consumers do not know these payments are exchanging hands. And recently leading national newspapers published editorials supporting the Physician Payments Sunshine Act. Industry and consumer groups alike are calling for CMS to act on this piece of legislation.

With all of this support, I would like to ask you what the delay that has occurred is all about.

Secretary SEBELIUS. Well, Senator, we share your interest in making sure that this act is fully realized and think it is a very important issue for consumers to know exactly what is going on.

We had a proposed rule in December 2011. The comment period closed on February 17. So about 3 weeks ago. We are working with comments and stakeholders and we fully intend to publish a final rule later this year so our collection of data can begin before the end of 2012. And we would be eager to work with you on full implementation.

Senator KOHL. Could I request that you make a strong effort to push up that implementation time to no later than the first half of this year?

Secretary SEBELIUS. Well, as I say, we have got the comments in and, again, we will work aggressively to get this in place. But the comment period closed on February 17, and we are doing outreach to stakeholders and others reviewing the comments and we will make every effort to get it published as soon as possible and get data collection beginning this year.

Senator KOHL. Thank you very much.  
 Senator HARKIN. Senator Kohl, thank you.  
 Senator Graham.

#### AFFORDABLE CARE ACT WAIVERS

Senator GRAHAM. Thank you, Mr. Chairman.  
 Thank you, Madam Secretary, for coming over.

Very quickly about the waivers. As I understand it, there have been, oh, several million people covered by a waiver from your Department basically saying to the healthcare entity we are going to

waive the requirements in Obamacare for your organization. Do you know how many people have received that waiver?

Secretary SEBELIUS. Senator, again, there are a variety of different provisions of the law where we were given some administrative authority. So people in the so-called mini-med plans who had some kind of health coverage but not a robust plan—a number of those employers were given waivers knowing that the mini-meds cease to exist in—I can get you in writing the numbers and the different categories, but I do not know off the top of my head.

Senator GRAHAM. I would appreciate that.

What percentage of those plans are union plans?

Secretary SEBELIUS. I can tell you in the waivers that we have given, the union waivers were, I think, the fourth-lowest category. Private employers were number one. City and State governments were number two. I think the education system was number three, and then I think union plans were in the fourth category.

Senator GRAHAM. Okay. So city and State governments. Union plans were four.

What I would like from you is a detailed analysis of the number of waivers given, the number of plans affected, the number of people within those plans, and what percentage of those plans happen to be union plans.

Secretary SEBELIUS. I would be glad to do that.

[The information follows:]

Starting in 2014, the Affordable Care Act bans annual dollar limits on coverage of essential health benefits. Until then, annual limits are restricted under the Department of Health and Human Services (HHS) regulations published in June 2010.

For plan years starting between September 23, 2010 and September 22, 2011, plans generally may not impose an annual dollar limit on coverage of essential benefits such as hospital, physician, and pharmacy benefits of less than \$750,000. The minimum annual dollar limit is \$1.25 million for plan years starting on or after September 23, 2011, and \$2 million for plan years starting between September 23, 2012 and January 1, 2014. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

A small number of workers and individuals currently have access to only limited-benefit, or “mini-med”, plans with lower annual limits than are generally permitted by law and which provide very limited protection from high healthcare costs. Estimates by employers and insurers indicate that requiring mini-med plans to comply with the new rules could cause mini-med premiums to increase significantly. This increase in premiums could force employers to drop coverage leaving some workers without even the minimal insurance coverage they have today.

In order to protect coverage for employees in mini-med plans until more affordable and more valuable coverage is available in 2014, the law and regulations issued on annual limits allow HHS to grant temporary waivers from this one provision of the law (PHS Act, section 2711(a)(2)) if compliance with annual-limit requirements would result in a significant decrease in access to benefits or a significant increase in premiums. Plans that have received such waivers must comply with all other provisions of the law, and, as a condition of the waiver, were required to alert consumers that the plan has restrictive coverage and includes low annual limits. Additionally, these waivers are temporary and after 2014, no waivers of the annual limit provision are allowed.

The following chart breaks out approved waiver applicants by type. Please note that the annual limit waiver data is publicly available at [http://cciio.cms.gov/resources/files/approved\\_application\\_for\\_waiver.html](http://cciio.cms.gov/resources/files/approved_application_for_waiver.html) and includes: applicant information, denials, reconsiderations, and health reimbursement arrangements.

Type of Plan	Number of Waivers
Self-Insured employers .....	722
Multi-Employer plans .....	417
Non-Taft Hartley union plans .....	34

Type of Plan	Number of Waivers
Health insurance issuers .....	50
State-Mandated policies .....	5
Association plans .....	3

#### MEDICAID FUNDING

Senator GRAHAM. I appreciate that.

Now, Medicaid. You know this program well. In South Carolina, as I understand it, if the Medicaid eligibility is expanded and implemented in 2014 as envisioned by Obama healthcare, my State will be required to come up with close to \$1 billion of new State funding over a 6- or 7-year period. That is pretty true throughout the country. Is it not?

Secretary SEBELIUS. No, Senator, it actually is not. And I had some of this discussion with Senator Alexander, and I continue to have it with Governors. The way the law is constructed, actually the first number of years of the plan is fully federally funded, 100 percent Federal funding.

Senator GRAHAM. How many years of Federal funding?

Secretary SEBELIUS. There are 4 years where it is 100 percent, and the Federal funding then goes from 100 to the lowest in a decade that the Federal Government contributes is 90 percent of the——

Senator GRAHAM. What about the next decade?

Secretary SEBELIUS. The next decade is not described in this bill, but what you are talking about is the budget window. What I keep hearing about is this concern that somehow in the next several years there will be \$1 billion in South Carolina taxpayer money and that——

Senator GRAHAM. I guess my concern is that we are expanding Government healthcare programs, to me, that need to be reformed, not expanded. And you may not hear this when you talk to Governors, but I sure hear it from Democrats and Republicans. They are worried to death about Medicaid expansion as proposed in Obamacare.

So I have got a simple proposition. Would you allow a State to opt out of Medicaid expansion if they chose to under Obama healthcare?

Secretary SEBELIUS. Senator, what we have supported from the beginning and actually asked that it be accelerated is if a State has a proposal to cover the same number of people, to provide health coverage, and has a different methodology for doing that, we would be eager to take a look at that and work with them around that.

Senator GRAHAM. Well, but my question is would you allow a State to just simply opt out because they have responsibility for their citizens. The only way they can opt out is to do it the way you approve of. Is that right?

Secretary SEBELIUS. Well, Senator, as you know, I do not even have the authority. Right now, the law provides for us to give an accelerated option to a State plan.

Senator GRAHAM. What if the Congress said to all the States if you want to stay in Obama healthcare Medicaid expansion, you

can, but if you want out because you think it is going to bankrupt your State, you have that option. Would you oppose that?

Secretary SEBELIUS. I would, Senator, without an alternative for what happens to those folks. Would they be eligible for the exchange which would be a more expensive strategy?

#### MEDICARE SOLVENCY

Senator GRAHAM. Well, I guess what I am saying is that Medicare and Medicaid are really Federal Government programs. Do you think Medicare is in a world of hurt financially?

Secretary SEBELIUS. I think that the long-term solvency of Medicare is a topic that needs to absolutely be discussed.

Senator GRAHAM. Would you agree that Medicare and Medicaid have grown in unsustainable ways, and without serious reform, those two programs alone are going to bankrupt the country? And I guess my concern is before you add another Government program where you subsidize the private sector with a Government plan, I would like to fix the two that are going to bankrupt the country. And do you have a plan to save Medicare from insolvency?

Secretary SEBELIUS. Well, as you know, Senator, in ACA, we began—

Senator GRAHAM. Does President Obama—and I will end this. My time is up. Does President Obama in his budget or anywhere else have a plan that would adjust the age for eligibility, means test for higher incomes in terms of premium subsidies? Is there a plan the President has come up with in the last 3 years to save Medicare from bankruptcy?

Secretary SEBELIUS. Has he proposed a means test or raising the age? No, Sir.

Senator GRAHAM. Has he proposed a plan to save Medicare from bankruptcy?

Secretary SEBELIUS. He has proposed certainly a plan that adds seriously to the life of Medicare. This budget continues that effort, and we are eager to work on an even longer-term strategy.

Senator GRAHAM. Finally, if Paul Ryan comes up with a plan to make Medicare more sustainable and fiscally sound over the next 75 years, would you at least applaud him for trying?

Secretary SEBELIUS. Well, I think that what I have seen so far, Senator, from Congressman Ryan is really blowing up the program as we know it, not sustaining it. But I would be eager to engage in any conversations about protecting beneficiaries, fulfilling our commitment to long-term health benefits, and finding a sustainable way moving forward.

Senator GRAHAM. Thank you.

Senator HARKIN. Senator Pryor.

#### HEALTHCARE EXCHANGES

Senator PRYOR. Thank you, Mr. Chairman.

I wish that Senator Johnson were still here because I think that if I understand correctly, Madam Secretary, the CBO at some point this month is going to update the healthcare baseline and give us some updated numbers about healthcare. So that will be helpful. But I would like to see those when they come out and maybe visit with you further about that.

Let me, though, jump into something that you mentioned a few moments ago in answering Senator Graham's questions about healthcare exchanges. I would like to get an update from you on where you are, as the Federal Government, but also where the States are in terms of setting up the exchanges. Where are they in that process?

Secretary SEBELIUS. Well, Senator, every State in the country, I think with the exception of two, have actually drawn down a planning grant. A number are moving ahead with the next level of implementation. We have laid out a strategy and are working actively with States around the country around basically a choice of three pathways. Either the State fully runs their insurance exchange and will be up and going and we will certify them for activity somewhere in 2013. A State can, on the other hand, engage in a so-called partnership program where the Federal Government will run pieces of the program and they will run other pieces. And the final is that they decide that they are fully not going to engage and that the Federal exchange will take care of the exchange activities in their State.

And States are in a variety of activities. A number have legislation pending this year. Some are issuing executive orders. So we will know more definitively by the end of this calendar year where exactly are the host of States because there are a lot kind of in that middle space where they are trying to figure out if they are going to be fully up and running or in a partnership.

Senator PRYOR. My impression is that the exchange part of healthcare reform is very important because it could—at least in theory—make health insurance much more available to many more people and hopefully you would get a better value for the dollars you spend on healthcare. So I would encourage you to keep pushing and keep trying that.

Secretary SEBELIUS. We definitely are.

#### MEDICARE FRAUD

Senator PRYOR. And also one other thing that Senator Graham asked about was Medicare and the sustainability of Medicare. I know that one of the things you have been working on is trying to come up with a better way to quantify the amount of real fraud in Medicare. And I think everybody in this room wants to do that and wants to know exactly how much fraud there is and how we can identify it and stop it better than we have in the past. So, as I understand it, you are working on some new measures on fraud. What is your timetable for trying to have these new fraud measures in place so we will have a better sense of how much actual fraud is in the system?

Secretary SEBELIUS. Well, I think, thanks to the resources that we were given as part of ACA, which actually is the toughest anti-fraud legislation ever passed in this country, we have some new data analytic tools. Part of that led to this takedown of the Texas doctor who allegedly committed about \$375 million worth of fraud with home health agencies. But part of it is a predictive analytic system that finally catches us up with the private sector. A lot of that is in place now.

Senator PRYOR. It is really great.

Secretary SEBELIUS. We did not have it 2 years ago and it is now there. We brought the billing systems into one place. We can now watch what is happening in one spot and share it with law enforcement.

Senator PRYOR. And it is in real time now?

Secretary SEBELIUS. You bet. You bet.

Senator PRYOR. That was one of the problems before.

Secretary SEBELIUS. It did not exist. There were 12 different billing systems with Medicare. So it was almost impossible to track what was actually happening real time.

Senator PRYOR. I would love it if some of your folks could come into our office.

Secretary SEBELIUS. We would be glad to do that.

Senator PRYOR. You do not have to do it. I know you have got staff who can brief my staff and me.

Secretary SEBELIUS. Now, Dr. Peter Budetti is the head of that unit, and we have never had an administrator at CMS who has actually been in charge of anti-fraud activity.

#### HEALTH PROFESSIONS

Senator PRYOR. Let me just make two really closing comments because I am going to run out of time here.

We have a program in Arkansas, the Arkansas Area Health Education Centers (AHEC) program. It works very well in our State. We have eight of these little regional offices. They are pretty much satellites of our medical school. They do a lot of training. They provide lots of important healthcare in eight different places around the State that people would not have access to otherwise.

I am concerned that when I look at the President's budget, we are looking at cuts there, and I am afraid about cutting those programs. I do not know about every other State, but our program works very, very well. It is really a key component of trying to provide better healthcare all across the State, and obviously, like some other States here, we have some poverty issues and some real challenges in rural Arkansas trying to get healthcare providers, specialists and even primary care physicians, nurses, and dentists to some places in our State. I would hope you would look at Arkansas because we have an AHEC program that works very well. In fact, Senator Tom Coburn—medical doctor—is a product of that. He actually went through the Arkansas AHEC in western Arkansas.

And the last thing I wanted to say is just thank you for helping with a Bureau of Health Professions issue. I want to thank you all for working very diligently to help correct a provider shortage designation in Lepanto, Arkansas, which again is one of these communities that just has almost no access to healthcare and you have paved the way for them to get a physician there in rural Arkansas. So thank you for doing that.

Secretary SEBELIUS. Good. Glad it worked.

Senator HARKIN. Senator Moran.

#### CRITICAL ACCESS HOSPITALS

Senator MORAN. Mr. Chairman, thank you.

Secretary, nice to see you. Glad our paths have crossed this morning.

Just a couple of questions. First of all, I assume that you had a role to play in the President's budget, and I wanted to raise with you or at least ask you to assure me that the cuts in the critical access hospital program you think are appropriate or necessary. The President's budget has a couple of proposals. One is a mileage restriction. Depending upon what that mile might turn out to be, it affects from a small number to a large number of critical access hospitals in Kansas, and then a reduction in the so-called 101 percent of costs to 100 percent of costs. And I think we would agree that the word "cost" does not cover the cost.

As you know, in our State, those critical access hospitals in many ways determine the future of a community, and the absence of their presence, no physicians, and the citizens reluctantly decide they no longer can call home home.

I wanted your thoughts on the reductions in spending related to critical access hospitals.

Secretary SEBELIUS. Well, Senator, you and I have talked about this in the past, and I do share your concerns about access to healthcare particularly in rural areas and know how important that is to community survival. I do think that in a better budget time, this would not have been recommended, but I think that the framework of a possible 10-mile differential, if there is another hospital within a 10-mile radius, then it is unlikely that that is a critical access hospital because there is another choice in a relatively close space.

And making sure that 100 percent of payment is paid—it is not reduced below 100 percent. It is 100 percent. I think working on then the definition of what that cost means is a secondary issue, and I would be glad to work with you on that. But paying 100 percent I think is very important.

Senator MORAN. Well, I would agree that if we actually paid 100 percent of actual costs, that is a different story than paying 101 percent of something less than costs or paying 100 percent of something less than costs. And so the definition of what is actual costs needs attention, and the percentage would become much less important if actual costs were actually covered.

I assume that the mileage change, if enacted, would be retroactive, would be current, and so hospitals that currently receive a critical access hospital designation would lose that. I would indicate that one of the things that has troubled me from the very beginning of this conversation about the mileage restriction is you can have two critical access hospitals within 10 miles, 25 miles, 20 miles, whatever that number is. Both of them then are affected by the change, and you lose the designation for both hospitals to be a critical access hospital, which very well may eliminate access anyplace within that region. And so this being prospective, taking into account the consequences to two hospitals in the same radius, I think this needs to receive greater thought than just a strict mileage requirement.

Secretary SEBELIUS. Well, and again, we would be happy to work with you on that issue because that certainly is not the intent. As you say, applied arbitrarily, what you described could happen, but we will be glad to work with you on that.

## NIH FUNDING

Senator MORAN. I welcome that.

The other topic I wanted to raise was NIH funding. The President's budget is a continuation of the current levels of funding. Budgeting is about priorities. And I understood from your testimony but from a conversation that you had with Senator Shelby, NIH indicates that—or at least the administration indicates that through new grant management policies, more can be done with less, I think is the summary of what is being suggested.

But I notice that, for example, the CMS budget goes up \$1 billion while the budget for NIH is held constant. And if there is more bang with the buck, more able to do more with less, I wonder why that is not applicable elsewhere and why it seems to be directed toward NIH. I worry when there is not a consistent availability of money at NIH, that we begin to lose the infrastructure, the commitment of young people to research and to science wanting to pursue that career and know that they have a place to go to work. I think NIH is critical in our global competitiveness, and ultimately in saving healthcare costs that the chairman talks about, preventive medicine, NIH has a significant component to play in finding the cures and treatments that in the long run save dollars. So in that sense, for the quality of life and for the economics, NIH is something that is very important, and while other items within your budget received increases, NIH did not. And those priorities—I would welcome your thoughts on that.

Before I run out of time 37 seconds ago, I have invited the Acting Administrator of CMS to Kansas, and I would ask you to help me accomplish that goal. Since I have been in the Congress now for 15 years, I have invited every CMS Administrator to come to our State. Over the years, two have accepted that invitation. And I certainly would welcome the opportunity to have Ms. Tavenner with us in Kansas and get a feel for how we deliver healthcare in our State and to meet with providers and patients. And if you can encourage your Acting CMS Administrator to join your Senator in your home State, I would appreciate that very much.

Secretary SEBELIUS. I will certainly follow up on that with Marilyn. I know she is eager to get out and about and around the country. So I did not know that invitation was pending.

Let me just, if I can, Mr. Chairman, briefly address the NIH situation, which again we share this priority.

I would say that the requests for the new resources at CMS are, one, due to the growing needs in both the Medicare program with the baby boomers coming in. There are about \$200 million dedicated to Medicare and Medicaid issues, and the \$800 million is, again, basically a one-time cost for infrastructure.

I do think the NIH budget with a new opportunity for clinical and translational science awards, which has an additional budget allocation with Dr. Collins able to allocate just under an 8-percent increase in new grants, about 670 new grants—we are trying to drive the resources toward just what you describe which is the most strategic way to keep not only young people involved and engaged but keep the acceleration of promising breakthroughs on the

horizon. And he feels that this is a budget that does accomplish those goals.

Senator MORAN. Thank you, Madam Secretary. I will submit a question to you in writing related to Part D preferred network plans. If you could respond to the subcommittee, have the Department respond to the subcommittee, I would appreciate it.

Secretary SEBELIUS. Sure.

Senator MORAN. Thank you, Mr. Chairman.

Senator HARKIN. Senator Landrieu.

#### HEALTHCARE REFORM

Senator LANDRIEU. Thank you, Madam Secretary. And I want to commend you for your tenacity and your focus on helping stand up a major reform, very few reforms of its nature in our Nation's history, as we try to press forward on the dream and goal of every American, being able to access affordable healthcare. It has been tried by many Presidents—Democrats and Republicans—in the past, and President Obama, with your leadership and with our help, despite organized and ferocious and in some cases vicious opposition from the other side, are actually beginning to implement the opportunity for every person, regardless of whether they come from a rural area, a suburban area, or an urban area, whether they are white, black, Hispanic, Asian, whether they have a full-time job or a part-time job, whether they have a pre-existing condition, a birth defect that they were born with, an accident that they get into, that they actually would not have to go bankrupt or die on the side of the road, that they would actually have quality care. It is quite remarkable.

There are only a few countries in the world that have achieved that, some at great expense. Others are struggling with it. There are only a handful of countries that are trying to be as sophisticated in their private-public partnership. And as you know, we are not doing that by running government programs. We are doing it in an attempt to work with the private sector to provide this kind of care.

And the numbers that you gave to Senator Alexander were particularly telling, that the cost per person seems to be coming down. Opportunities for new affordable insurance are showing themselves because I am personally a little tired of Republican Governors out there whining that the reasons that they have to cut higher education is because of the increase in spending for healthcare. Part of the reasons that their budgets are shrinking is because they are giving tax cuts they cannot afford. They are giving tax credits to corporations that should be paying taxes in their State.

The second point that I want to make, Mr. Chairman, is that it is not just the Federal Government's responsibility to provide healthcare services to our citizens. It is a responsibility of the State, the Federal Government, and local government. When did this become a complete Federal problem? So State Governors need to man up and woman up and do their job to provide funding necessary to help kids that are born with defects, birth defects, to help their people that get into car accidents and lose their legs, their arms, their eyes, their ears, lose their hearing, and stop whining.

Now, if they can come up with a better plan, if the Republicans—which they have not in 3 or 4 years or 5 years to fix this, then I will listen. Until then, we are going to implement the plan that we passed.

CHILD WELFARE AND ADOPTION ASSISTANCE

Now, my question, which is a small part of your budget, but as you know, it is my focus. Your entire budget, which is \$16.2 billion, does a tremendous amount of good to help families in America. I guess we have about 150 million families. We have 300 people, 2 people per family. I am just roughly estimating—125 million families. You do a lot in this budget for their health, for helping them with day care so many of our families can go to work, providing good healthcare.

A small number of our families, as you know, are very, very fragile and in critical situations, and we have tried with this subcommittee to give you some special funds to help keep these families together and particularly help children that get separated from their families. We call them orphans, children in foster care. They only represent one-half of percent of all the children in America are in foster care.

So I just want to point you to your Child Welfare and Adoption Assistance program of about \$362 million, the Chafee program \$45 million for training of foster youth, the \$39 billion for adoption incentives, and the \$63 million for promoting safe and stable families. We have worked across the aisle here for many years. While we do fight about healthcare, we really do not fight about adoption and foster care.

And I just want to ask you and bring to your attention that your Department, prior to you getting there but continuing under your good leadership, has increased the number of adoptions from 14,000 in 1990 to 52,000 this year. That is an incredible—

Secretary SEBELIUS. That is a big jump.

Senator LANDRIEU. It is a big jump, Madam Secretary, and I want to thank you. A lot of this work was done by the Clinton administration. This was a big priority for President Clinton and First Lady Hillary Clinton. But I think that is a real testimony, Mr. Chairman, to your leadership as well. We have increased domestic adoptions from 14,000 a year to 52,000 a year.

My question would be could you look more closely at these numbers that I have shared with you and see if you can more strategically align them with the goal of bringing this number up, Madam Secretary, from 52,000 to about 100,000. We have got to double it. That is the number of children that are available for adoption, but we are not connecting them well enough to a home. We are either failing to keep them with their birth families or we are not connecting them to be adopted. And you have got some resources in here specifically programmed by the Congress. So could you comment on that?

And I want to thank you for your appointment of George Sheldon who seems to be a real expert in this area and has been working closely with us on it.

Secretary SEBELIUS. Well, Senator, I would be remiss if I did not recognize your incredible leadership and tenacity around these

issues looking out for kids who often do not have a champion, and you certainly have been one.

We have a request before the Congress in this budget to increase spending by \$250 million in the foster care and permanency area, \$2.8 billion over 10 years. And it would be a new initiative to incentivize all kinds of improvements in foster care, requiring child support payments to be used in the best interest of the child rather than offset State and Federal welfare costs that often can be conflicting.

So we agree that resources need to be increased and we need to do a better job targeting those strategic resources to make sure that these programs are enhanced, and we would really look forward to working with you who have thought about this for a long time and have some, I think, very good ideas about how to improve the well-being of our children in foster care, the transitioning issues, I know, you know, the huge step to provide healthcare to the kids aging out of foster care, the same way that other kids can be on their parents' plan. These are our children. So carrying them on a healthcare plan.

We have a new proposal, Senator, that I will make you aware of which really deals with the reallocation of the State funding which currently is not accessed around abstinence-only education. A number of States have just said we are not going to take those resources. We would like to reallocate those funds and focus on pregnancy prevention in foster youth where the data is pretty alarming in terms of how many young girls end up becoming pregnant. So there are some strategies across our budget that I think focus some new resources.

Senator LANDRIEU. Well, I would only say, Mr. Chairman, you have been very generous, but you are both in an excellent position to focus on this because really focusing on the needs of foster children, particularly helping them stay in the schools that give them the stability. And, Mr. Chairman, as the chairman of the Education Committee, I think there can be a tremendous amount of—there is a lot of interest of Senators on both parties, and I think we can make advancements.

But remember that the best support for a child is a good parent. You know, we can give all the government services we want, but if we could just help these children get into the arms of a loving, responsible adult, either to the mother that they were born to with help and support or to an aunt or a kin or a relative or to someone in the community, that is the best prevention of pregnancy and jail and mental illness is to have a good, loving parent. So if we could just focus our efforts, build on this great, extraordinary work—we have doubled the number of children finding forever-homes—I would be grateful and so will the children.

Secretary SEBELIUS. I look forward to working with you.

#### COMMUNITY TRANSFORMATION GRANTS

Senator HARKIN. Thank you very much, Senator Landrieu. And I join the Secretary in thanking you for your great leadership in all the years you have been here in this area. I think you have provided just sort of a beacon for the rest of us to follow in how we are going to address this issue of our foster kids and kids that just

have a tough life and making sure that they just have a little bit more gentle care and loving care. So I thank you for your great leadership in that area.

Madam Secretary, I am going to start a second round, but I guess I am going to be the only one.

The one other thing I want to cover with you is something near and dear to my heart that I have worked on for a long time. I put it in ACA as part of the prevention and wellness program, and it was called Community Transformation Grants. This was based upon earmarking things that we had done in the past and looking at what the community has done. We had some tests around the country to see how communities could come to join together, such as getting grocery stores, YMCAs or YWCAs, schools, businesses to figure what they could do in a community-based setting to provide for healthier lifestyles. And that is why it was called a Community Transformation Grant.

In fiscal year 2011, \$145 million was allocated to this Community Transformation Grant. The CDC announced a competition that, for most of the country would require statewide programs. For example, in Iowa, Dubuque or Des Moines could not apply on their own; they had to be part of a statewide application. Well, that is not what we intended. As I look at the guidance put out by CDC, to be eligible, grantees had to serve either a city of 400,000 or more or a State. So in most States, YMCA or community health centers could not even apply directly. Grants were for \$1 per capita.

I often cite the Trust for America's Health. They did a very thorough study on this, and they found that investments in prevention could produce savings within 5 years based upon spending of \$10 per person.

So we can take that \$145 million and just sort of spread it around, but I am not certain it is going to have that much of an impact unless it is targeted. So that is why we wanted it to be community-based programs.

Also, the CDC said funding must be used on a minimum of three goals, reducing obesity by 5 percent, reducing smoking rates by 5 percent, increased access to preventative services by 5 percent. Now, again, maybe States are equipped to do all that, but in a lot of cases, community groups have just one focus. The CDC is now making them focus on the three specific goals.

Well, that is not what we intended. So in our Senate bill last year, we got language in there to continue the program your Department designed but requiring that all new funds be used to support community-based programs. As I said earlier, because of the opposition by the Republicans on the Senate side and the House Republicans, we were not able to get the bill through. However, the language is there in the Senate bill.

What I would like to seek from you is a commitment that the \$81 million increase that we had this year. I want to make sure that all new funding is in accordance with the language we put in the Senate bill. I cannot do anything about the \$145 million. It is already out there. And I just wanted to know your sentiments on that.

Secretary SEBELIUS. Well, Senator, Mr. Chairman, I certainly share your belief, although you have been at this a lot longer than

I have, that the ounce of prevention is probably 10 pounds of cure. I mean, it is a strategy that we have to engage in. We think Community Transformation Grants can be a critical part of that testing strategies. As you know, there are some set-asides for rural communities and tribal communities to make sure that there is a representation in rural and frontier areas as well as larger communities and statewide programs.

So 61 States and communities had received awards in 2011, and I know your interest in broadening the applicability. We will work with your office around the framework for moving forward. There are some issues around how many folks can really move the needle, but we would be eager to work with your office around what the next steps are.

Senator HARKIN. Well, I appreciate that. Take a look at the language that we put in. I would love to work with you on it. This is something that we have been doing for a long time on this subcommittee, and we funded, as I said through the earmarking process, and some have failed, some have not. We kind of know what works, and it is on a community basis, not on a statewide basis. And certainly I never intended that it would only go to cities of 400,000 or more. Sometimes the smaller community can have a bigger impact just because they are smaller, people know each other, they can get together better in a smaller community sometimes. So a community of 40,000–50,000 can make great strides even better than perhaps a large metropolitan area. And then the idea of \$1 per person might have some effect, but certainly not the kind of impact that a larger amount in more targeted areas would have. So I look forward to working with you on that.

#### NIH FUNDING

Last, I wanted to bring up the issue of community health centers, again something that we worked very hard on in ACA. Senator Sanders was also one of the leaders in that area on the authorizing committee. But we wanted to increase the number of community health centers prior to 2014. We wanted to get as many out there as possible. Yet, the President's budget proposed to hold back \$280 million of the \$300 million increase for fiscal year 2013. That is the budget we are working on.

Now, I know all about the funding cliff that is out there in 2015, but that funding cliff was about \$3.6 billion. Our intention on putting this money in there was to get as many community health centers up and running prior to 2014. It was not to smooth it out.

So again, I am hopeful that we can use all of the additional \$300 million to get as many centers up and running as possible before January 2014. We can worry about and take care of that funding cliff sometime later, but the most important thing is to get them up and running.

Secretary SEBELIUS. Well, again, Mr. Chairman, I think your interest and passion in this area is not only well known but one that we share. Community Health Centers have been a resounding success, high-quality, lower-cost, preventive and primary care, often taking care of needs well beyond healthcare that impact people's health and well-being. As you know, the budget does anticipate an additional 200 sites be funded with the resources that we have re-

quested, but we would again work with your subcommittee. I think there is a great deal of concern about the out-years and the cliff and how to make sure that we do not end up in a situation where having opened a lot of sites, we cannot staff them, we cannot fund them. So we would be eager to work with you around the best strategy to get people the desperately needed care.

Senator HARKIN. Well, thank you, Madam Secretary. Just tell OMB I am not in favor of what they are trying to do. All right?

Secretary SEBELIUS. I would be happy to convey that message.

#### ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. Madam Secretary, thank you. Do you have anything else that you want to add for the record?

Secretary SEBELIUS. No, Sir.

Senator HARKIN. Thank you very much.

Secretary SEBELIUS. Thank you.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

#### QUESTION SUBMITTED BY SENATOR TOM HARKIN

##### NATIONAL HEALTH SERVICE CORPS AND TITLE X

*Question.* To receive title X funding, a clinic is required to prove to Health Resources and Services Administration (HRSA) that they either provide or have in place referral agreements to provide comprehensive primary care services. Yet the Guttmacher Institute has shown that the biggest hurdle for title X clinics that want to participate in the National Health Service Corps (NHSC) is proving that they provide or have referral agreements to provide comprehensive primary care services. If HRSA is certain the clinics provide those services in one ongoing grant program and audits them regularly to ensure compliance, why would good standing in that program not be sufficient proof of those services for another HRSA program?

Clinics that only receive title X funding provide the only primary care many low-income women receive, and they are plagued by the same workforce shortages as other clinics. Obstetrician/gynecologist and nurse midwife are two eligible categories for health professionals who participate in the NHSC. Furthermore, like other NHSC-eligible entities, clinics with only title X funding are required to serve anyone who walks through the door—women and men—in their communities regardless of income at free or reduced cost. What plans does the Department have to ensure that HRSA programs have a common definition for what constitutes providing comprehensive primary care services?

*Answer.* The NHSC has taken steps through its refined policy to better inform sites of the program's definition of comprehensive primary care so that the site approval process is open and transparent. The program recognizes that many women, as well as men, use women's health clinics as their primary care provider because it meets their healthcare needs or may be the only provider in their community.

The NHSC has published a new version of its Site Reference Guide, which defines comprehensive primary care as, "the delivery of preventive, acute, and chronic primary health services in an NHSC-approved specialty. NHSC-approved primary care specialties are adult, family, internal medicine, general pediatric, geriatrics, general psychiatry, mental and behavioral health, women's health, and obstetrics/gynecology. Comprehensive primary care is a continuum of care not focused or limited to gender, age, organ system, a particular illness, or categorical population (e.g. developmentally disabled or those with cancer). Comprehensive primary care should provide care for the whole person on an ongoing basis."

## QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUE

## NATIVE HAWAIIAN HEALTHCARE

*Question.* I appreciate that under your leadership the budget request for the Health Resources and Services Administration (HRSA) continues to support the Native Hawaiian Health Care Program, which improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Health Care Systems. As you may be aware in 2010, the Department of Health and Human Services (HHS) consultation policy as related to American Indians and Alaska Natives was revised and the new formal consultation policy eliminated Native Hawaiians and their health organizations (NHOs). It is my understanding, that since that time Native Hawaiians and their NHOs have asked HHS to re-establish a separate formal consultation policy for Native Hawaiians. Native Hawaiians have among the highest morbidity rates of any ethnic or racial population for major chronic diseases, and consultation with the Native Hawaiian community could help to tailor HHS policies, programs, and priorities to improve health outcomes. Please describe the best path forward for HHS and the Native Hawaiian community to engage on health issues of concern. Is the reissuance of an HHS consultation policy for Native Hawaiians and their health organizations possible?

*Answer.* HRSA understands the importance of supporting the Native Hawaiian Health Care Program, and will review existing relationships and partnerships with the Native Hawaiian community to determine the appropriate steps for moving forward, including the consideration of revised policies.

*Question.* The Native Hawaiian Health Care Improvement Act (42 U.S.C. 11701) is the major Federal statute providing for a comprehensive approach to improving the health and well-being of the indigenous peoples of Hawaii. The act states that the Secretary of HHS provide the President with a progress report on meeting the Federal policy of "improving the health of Native Hawaiians to the highest possible level." The President, in turn, transmits the report to us in the Congress. When can my office anticipate receiving a copy of that report?

*Answer.* HHS is committed to addressing the health needs and well-being of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations. The Affordable Care Act (ACA) has mobilized HHS efforts and has served as the underlying framework for the development of the HHS AANHPI Agency Plan. The HHS plan illustrates measurable objectives that the Department will pursue to raise the visibility of AANHPI health issues, healthcare and human services disparities. This plan is meant to elevate AANHPI issues across the Department under the leadership of the Assistant Secretary for Health. I am pleased to provide a copy of the agency plan to your office which outlines, in detail, the components and accomplishments related our current work on improving data collection.

The plan includes four overall-arching health goals to improve the well-being of AANHPIs. These goals include how the Department will carry out its plan to prevent, treat and control Hepatitis B infections in AANHPI communities, work to improve reporting of data, foster workforce diversity by developing workforce pipelines for AAs and NHPs, and address some of the key health issues that specifically impact NH and PI populations. The plan also addresses a wide-ranging set of issues, including breast and cervical cancer, diabetes and tuberculosis, prevention, surveillance and response, communicable diseases in the Pacific jurisdictions, laboratory testing, environmental issues, and vaccinations.

Our efforts to better serve Native Hawaiian populations and identify and understand health disparities will be enhanced through the efforts outlined in goal two. Detailed data is a fundamental step in identifying which populations are most at risk and what specific interventions are most effective in attaining improved healthcare quality for specific populations. HHS will continue to increase the capacity to collect more reliable health data for AANHPI populations to better understand the need of these growing populations. Efforts to improve data collection include:

- Substance Abuse and Mental Health Services Administration:
  - Enhance the quality of data collected within Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use & Health (NSDUH) for AANHPI populations.
- Centers for Disease Control and Prevention:
  - The fiscal year 2013 budget includes \$161,833,000 for health statistics, an increase of \$23,150,000 more than the fiscal year 2012 level to accomplish many of the activities described below.
  - Continue oversampling of Asian Americans in the National Center for Health Statistics' (NCHS) National Health Interview Survey (NHIS).

- Include an oversampling of Asian Americans in the 2011–2014 National Health and Nutrition Examination Survey (NHANES).
- Implementation of section 4302 of ACA regarding data collection on race, ethnicity, sex, primary language, and disability status. This will provide an opportunity to obtain disaggregated data on AA, NH, and PI communities.
- Develop improved tools for accessing and analyzing vital statistics and survey data for small populations.

We look forward to improving our data collection, reporting and disaggregation of race, ethnicity, and primary language data related to the AANHPI community and to provide you with additional data related to the health objectives outlined in the Native Hawaiian Health Care Improvement Act. We look forward to including this information in the annual AANHPI Agency Plan end of year report.

#### ALIGNING HAWAII'S PREPAID HEALTH CARE ACT AND THE AFFORDABLE CARE ACT

*Question.* Hawaii has traditionally experienced a much lower rate of uninsured individuals due to the landmark State law, the Prepaid Health Care Act (PHCA), which requires employers to provide healthcare coverage to full-time employees. As the State works to implement elements of ACA, questions have arisen regarding the ability for Hawaii's law to interact with the ACA in a manner that would allow Hawaii residents maximum benefits. Will there be further guidance from HHS, specific to Hawaii's healthcare environment, on how the Prepaid Health Care Act can work in conjunction with the requirements of the ACA? Is it HHS' desire for Hawaii to maintain the requirements of the PHCA?

*Answer.* HHS is committed to working with the State of Hawaii regarding the coordination of the PHCA and ACA. HHS also works with our Federal partners in ACA implementation, such as the Department of the Treasury and the Department of Labor, on these issues, as necessary. Conversations about specific interactions have already begun.

#### COMPACT OF FREE ASSOCIATION

*Question.* In 1986, the United States entered into Compacts of Free Association with the Federated States of Micronesia and the Republic of the Marshall Islands. In 1994, the United States entered into a similar relationship with the Republic of Palau. The Compacts set forth the bilateral terms for government, economic, and security relations between the United States and the Freely Associated States (FAS), and the laws approving the Compact set forth the U.S. policy context and interpretation for Compacts. Section 141 of the Compact provides that certain FAS citizens "may be admitted to, lawfully engage in occupations, and establish residence as a nonimmigrant in the United States and its territories." However, the Congress also stated, in section 104(e)(1), that "it is not the intent of Congress to cause any adverse consequences for an affected jurisdiction." It is estimated that affected areas of the United States are spending upwards of \$200 million annually for healthcare, education, and other services for FAS migrants, including high-cost treatments such as dialysis and chemotherapy. These costs are increasing annually. Public health officials are particularly concerned about the rate of certain diseases such as tuberculosis and Hansen's disease, which have high incidence rates in Micronesia and among recent Compact migrants.

House Report 112–331 directs the Department of the Interior to "meet regularly with officials from the Freely Associated States, other Federal agencies and affected jurisdictions, and develop and implement a comprehensive plan to mitigate the costs of Compact migration." Please provide an update on the work of agencies within HHS on this interagency working group. How best can HHS assist States and territories in meeting the health and social service needs of Compact migrants?

HHS/Office of Assistant Secretary for Health (OASH), Region IX assists States and territories in meeting the health and social service needs of Compact migrants by managing the following activities:

- The OASH, Region IX office is coordinating with other HHS Operating Divisions (OPDIVS) on Pacific health issues; providing guidance on strategies and policy development that promote Pacific health and reduce health disparities; and participating in meetings of the Workgroup on Asian, Native Hawaiian, and Pacific Islander issues (WANHPPI) and Insular Areas HHS Policy Group (IHHSPG).
- The OASH, Region IX office is developing relationships with Micronesian Chief Executives Summit (MCES) policy leaders to advocate for increased health awareness, environmental health issues, and health disparities reduction; ensuring health and environmental health issues are elevated on the MCES agen-

- da; and participating in semiannual MCES meetings to promote status of health and environmental health issues.
- The OASH, Region IX office is improving the capacity to secure grants, and strengthen grant management and financial accountability capacity in the Pacific by increasing grant awareness by making knowledge of Federal grant funding opportunities more readily available to U.S. Associated Pacific Islands (USAPI) health departments and communities.
  - The OASH, Region IX office is promoting awareness of noncommunicable diseases (NCDs) crisis and Federal, nongovernmental organization (NGO) and international assistance for programs and policy development to prevent NCDs.
    - HHS Region 9 (RIX) is collecting NCD plans and promising practices from all the Pacific jurisdictions, report is forthcoming.
    - NCD program funding from CDC's consolidated grant program addresses diabetes prevention and treatment, tobacco control, and behavioral risk.
    - The Pacific Chronic Disease Coalition, a PIHOA affiliate, has been extremely active in supporting the development of NCD prevention programs in all of the USAPI.
  - The OASH, Region IX office is assisting Pacific health departments in addressing current, emerging, and emergency health issues including MDR-TB, Hansen's disease and dengue fever coordinating with CDC, HRSA, Department of Defense (DOD), World Health Organization, Pacific Regional Office (WHO/WPRO) and Secretariat for the Pacific Community (SPC), and DOI.
  - The OASH, Region IX office is involved in conversations with States and territories receiving Compact migrants, clarifying the circumstances in which Medicaid can be used to pay for emergency services. Although Compact migrants are not eligible for Medicaid, certain emergency services can be covered under the Medicaid program at the regular Federal Medical Assistance Percentage (FMAP).
  - The OASH, Region IX office is increasing the collection, accuracy, and utilization for health services of Maternal-Child Health (MCH) data in the USAPIs. In collaboration with HRSA's Title V MCH grant program, and in conjunction with WHO/WPRO, SPC and PIHOA data strengthening/HIT, there are efforts to determine weaknesses and revisions in current data collection, analysis, and utilization for health planning and service delivery.
  - The OASH, Region IX office is providing technical assistance to the USAPI nursing programs, including the Robert Wood Johnson (RWJ) Pacific PIN nursing grant, to enhance the capacity and quality of USAPI nursing programs.
  - The OASH, Region IX office is fostering recognition of the behavioral/mental health disparities in Pacific populations and creating resource linkages with potential resources SAMHSA, HRSA, CDC, Veterans Affairs, DOD, HI & Pacific M/DOH, NGOs including faith-based organizations, WHO/WPRO, and SPC.
  - The OASH, Region IX office is assisting USAPI health profession programs in incorporating emergency response content into their curricula. Coordinating with WPRO/WHO, CDC, ASPR, Medical Reserve Corps (MRC), HRSA, DOD, and the Red Cross regarding trainings and emergency prep curricula for health professions programs and assisting in establishing contacts to aid them in providing relevant trainings to nursing personnel and nursing programs.
  - The OASH, Region IX office is collaborating with Office of Minority Health Resource Center (OMHRC), HRSA, CDC, SAMHSA, WHO/WPRO, SPC, PIHOA, DOI, and Telecommunications and Information Policy Group (TIPG)/Pan-Pacific Education and Communication Experiments by Satellite (PEACESAT) on training opportunities for enhancing data, surveillance programs, and the combined utilization of HIT and tele-health to enhance service delivery and accessibility, to enhance capacity in data collection/analysis/surveillance that leads to better health services planning and service delivery.
  - The OASH, Region IX office is assisting in enhancement of the RIX Medical Reserve Corps program in the Pacific, collaborating with RIX MRC consultant to develop and strengthen MRC units in the Pacific.
- HHS/HRSA and CDC assists States and territories in meeting the health and social service needs of Compact migrants and Hansen's disease by managing the following activities:
- HRSA's National Hansen's Disease Program (NHDP) offers assistance in selected aspects of HD control, such as training and technical assistance in the Republic of the Marshall Islands (RMI). NHDP intends to collaborate with other agencies such as CDC and WHO to assist in HD awareness and training and participate in activities similar to the meeting with WHO and others in Majuro in 2010, and the HD training workshop at NHDP headquarters in Baton Rouge.

NHDP initiated preliminary training via video teleconference through PEACESAT in collaboration with HHS Region IX.

—CDC provides technical assistance for the public-health related aspects of HD, including development and evaluation of surveillance systems, epidemiologic support such as outbreak and cluster investigation, and case reporting. The CDC notifies state and territorial health departments and the NHDP of patient immigration into the United States, facilitating patient care. In addition, the CDC is providing direct assistance for capacity development of the RMI TB Control Program.

#### HIV/AIDS PREVENTION FUNDING

*Question.* The fiscal year 2013 President's budget request includes an increase of \$40.231 million more than fiscal year 2012 level for Domestic HIV/AIDS Prevention and Research. The increase provides additional funding to achieve the goals of the National HIV/AIDS Prevention Strategy. What measures will HHS use to assess the impact of the funding priority and will the funds targeted for State and local programs be prioritized to states and localities most impacted by previous shortfalls?

*Answer.* CDC aligns its HIV program priorities with the National HIV/AIDS Strategy (NHAS). The agency uses data from national HIV surveillance, behavioral surveillance, and program monitoring systems to assess progress toward achieving NHAS goals, as well as its own HIV prevention plans' impact objectives. These measurements, which are listed on page 80 of CDC's proposed budget for fiscal year 2013, are as follows:

##### *Prevent New HIV Infections*

By 2015, reduce the annual number of new HIV infections by 25 percent—NHAS goal.

By 2015, reduce the HIV transmission rate by 30 percent—NHAS goal.

By 2015, increase the percentage of people living with HIV who know their serostatus to 90 percent—NHAS goal.

Increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not Stage 3: AIDS)—2013 target: 47.5 percent.

Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active—2013 target: 86.9 percent.

##### *Increase Linkage to and Impact of Prevention and Care Services With People Living With HIV/AIDS*

By 2015, increase the percentage of persons diagnosed with HIV who are linked to clinical care to 85 percent—NHAS goal.

Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to partner services—2013 target: 73.5 percent.

Increase the percentage of HIV-infected persons in CDC-funded counseling and testing sites who were referred to HIV prevention services—2013 target: 68 percent.

Increase the number of States that report all CD4 and viral load values for HIV surveillance purposes—2013 target: 36.

Increase the number of States with mature, name-based HIV surveillance systems—2013 target: 50.

Reduce the number of new AIDS cases among adults and adolescents per 100,000—2013 target: 12.7.

CDC actively monitors and publicly reports on these national objectives each year as data are available. In addition, CDC's Division of HIV/AIDS Prevention aligns its program priorities with the principles of high-impact prevention, which represent the scientific foundation for its HIV prevention efforts. More information is available at: <http://www.cdc.gov/hiv/strategy/hihp/>.

In order to monitor progress at the State and local level, CDC asks grantees to submit semi-annual progress reports that describe the implementation of HIV prevention program activities, and identify barriers and challenges to meeting programmatic objectives. CDC also uses site visits and conference calls with grantees, and its own surveillance and monitoring systems, to monitor grantee performance and develop plans for further improve performance, which involves the provision of capacity building, training, or other technical assistance.

CDC would use the increased funding requested for fiscal year 2013 to address priorities in NHAS. Specifically, CDC would increase HIV Adolescent and School Health funding over the fiscal year 2012 level for cooperative agreements to States, cities, territories, and tribes. This would enable HIV priority areas to develop and implement health policies, programs, and practices, as well as improve HIV and sex education efforts across the country. CDC would also restore funding to several national NGOs that provided professional development and technical assistance to

State and local education agencies, health agency partners, and other organizations working in school health.

Of the increase proposed for HIV Prevention by Health Departments and National Programs to Identify and Reach Highest-Risk Populations, CDC would award \$22 million directly to State and local health departments. The increased funds are expected to improve the capacity of jurisdictions to conduct core HIV surveillance activities, and improve the use of surveillance and other programmatic data to improve HIV testing, retention, and re-engagement in medical care activities. Through its recent funding opportunity announcements, CDC emphasized the importance of aligning resources to better match the geographic burden of the HIV epidemic throughout the United States. This resulted in an equitable approach to CDC's HIV funding; additional funding for CDC would reflect a continuation of this approach. It is likely that a proportion of jurisdictions that experienced decreases in HIV funding would be recipients of these increased funds for HIV surveillance and prevention; however, CDC will prioritize the distribution of increased resources according to the burden of HIV.

#### VIRAL HEPATITIS SCREENING

*Question.* The Congress enacted \$10 million under ACA in fiscal year 2012 for viral hepatitis screening. Please provide an overview of how the funds were utilized. Additionally, please provide an overview of how local and State health departments are participating in the formation and implementation of the national viral hepatitis strategy.

*Answer.* In fiscal year 2012, CDC will use the increase provided for viral hepatitis to increase the proportion of persons with chronic viral hepatitis who are aware of their infection and who are referred to medical care. CDC is planning projects that involve direct provision of screening for at risk populations, evaluation of testing activities, and public and provider education to raise awareness of the need for viral hepatitis screening and provide the skills to do so. Specifically, CDC will provide resources to organizations to increase testing for at risk populations in multiple settings including federally Qualified Health Centers, local health department clinics (e.g., STD clinics or HIV/AIDS settings), correctional settings, intravenous drug use treatment centers, and community-based organizations. The resources will target efforts to reach persons at highest risk for severe hepatitis C virus (HCV)-related morbidity and mortality, communities experiencing health disparities related to hepatitis B (e.g., foreign born populations and their children) and hepatitis C (African Americans and current and former incarcerated populations), and young persons at risk for HCV-related to drug use. CDC will support a public awareness campaign for HCV, currently under development, and expand it to address chronic hepatitis B virus (HBV)—targeted to those populations most at risk for chronic HBV infection. CDC will also develop and disseminate education and training materials targeting public health and private sector healthcare professionals. These materials will build capacity to assess, test, and medically manage chronic HCV and HBV infection.

HHS invited partners from State and local health departments, including HIV and STD directors and Adult Viral Hepatitis Prevention Coordinators (AVHPC), to participate in the development of Combatting the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis (Action Plan). In particular, health department representatives participated in two community engagement meetings held by HHS on June 29, 2010, and September 21, 2010, with health departments constituting a significant percentage of the participants at both meetings. At the first meeting, participants had the opportunity to comment on issue areas proposed by HHS, propose additional areas, suggest particular issues that HHS should address, and identify ways to make the Action Plan as meaningful and useful as possible. Input from that engagement session strongly influenced and helped to shape the draft of the Action Plan. After developing the first draft of the Action Plan, HHS held the second meeting to solicit feedback about its contents. Health department representatives and other viral hepatitis stakeholders offered suggestions to strengthen, improve, and focus elements of the Action Plan. This feedback was a vital component in development of the final version of the Action Plan.

HHS and CDC will continue to work closely with state and local health departments to achieve the goals set forth by the Action Plan. The Action Plan recognizes the important role health departments must play in coordinating local efforts to advance viral hepatitis prevention and control activities. Numerous action steps in the Action Plan specifically mention AVHPC and other health department staff.

## TUBERCULOSIS IN HIGH-RISK AREAS

*Question.* Senate Report 112–084 requested that the CDC “review the epidemiology of TB in States and territories with more than double the average rate of TB cases.” Please provide a status update on CDC’s findings.

*Answer.* CDC analyzes and reports tuberculosis (TB) cases and rates annually. Jurisdictions with case rates that are more than twice the national average rate of 3.4 cases per 100,000 (provisional 2011 data) include Alaska (9.3), Hawaii (8.95), and the District of Columbia (8.9). Territories with more than twice the average national rate include the Commonwealth of the Northern Mariana Islands (67.3), Guam (55.3), Federated States of Micronesia, (136.7), the Republic of the Marshall Islands (227.7), and Palau (47.7).

## CHILDREN’S HOSPITALS GRADUATE MEDICAL EDUCATION

*Question.* The President’s budget for fiscal year 2013 proposes \$88 million to fund the Children’s Hospitals Graduate Medical Education (CHGME) program. CHGME was funded at a level of \$267.8 million in 2012. Even at CHGME’s current annual funding level, children’s hospitals struggle to train enough pediatricians and pediatric specialists to keep up with the growing demand. CHGME funds support graduate medical training at freestanding children’s hospitals all over the United States. The importance of this program is especially acute in my home State where our CHGME recipient hospital—Kapiolani Medical Center for Women and Children—is the only tertiary children’s hospital for the entire State of Hawaii and Pacific Basin. Kapiolani currently trains 6 to 10 pediatric residents per year and of the those trained, more than 30 percent choose to continue to practice in Hawaii after their residency. I am concerned that the proposed level of funding does not adequately support the gains we have made in pediatric health and ensuring access to care. If CHGME is not adequately funded, who will train these providers and support the future primary care workforce for our Nation’s children?

*Answer.* We recognize the vital role that children’s hospitals and pediatric providers play in providing quality health care to our Nation’s children.

The fiscal year 2013 CHGME funding level continues to support direct costs for training pediatric residents at independent children’s hospitals. This payment provides support for resident salaries, expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, cost associated with providing the GME training program, and allocated institutional overhead costs.

The fiscal year 2013 budget retains the incentive to maintain total resident levels. The administration recognizes that research has indicated that there is a significant shortage of pediatric subspecialists, resulting in children with serious illnesses being forced to travel long distances—or wait long periods—to see a pediatric specialist. In response to these shortages, the fiscal year 2013 President’s budget includes \$5 million to implement the Pediatric Specialty Loan Repayment (PSLR) program that was authorized in ACA. Under this program, loan repayment agreements will be authorized for pediatric specialists who agree to work in underserved areas.

While both the CHGME Payment and the PSLR programs support the pediatric medical workforce, the focus of each is different. The CHGME Payment Program serves the purpose of providing residency training in Children’s Hospitals through the payments made to Children’s Hospitals, while the PSLR program is designed to assist pediatric specialists more directly and increase the number of pediatric specialists in underserved areas.

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 QUESTIONS SUBMITTED BY SENATOR HERB KOHL

*Question.* Secretary Sebelius, more than a year ago I wrote to you with Senator Snowe to express strong concern about proposed regulations that your Department has drafted regarding the Genetic Information Nondiscrimination Act (GINA). We raised two concerns. First, the proposed rule extends to private long-term care insurance the prohibition under GINA of the use of genetic information. This extension occurred despite clear congressional intent and history to exclude GINA in long-term care. Second, we objected to the proposed GINA expansion because a rule barring the use of genetic information would effectively cripple the long-term care insurance industry and leave millions without access to coverage.

Given that Federal efforts to expand long-term care coverage have stalled and the administration’s decision not to implement the Community Living Assistance and Support Services (CLASS) program, this proposed expansion comes at a particularly precarious time for the long-term care industry. As we are relying on private indus-

try to accelerate its efforts and provide more coverage, the Federal Government should not inappropriately stymie these efforts.

Will you assure that the Department of Health and Human Services (HHS) will eliminate its expansion of GINA to long-term care insurance and continue to allow private long-term care insurers to use genetic information in the final rule, as the Congress intended?

Answer. I appreciate your concerns with the Department's proposed rule, which would prohibit long-term care insurers from using genetic information for underwriting purposes. A final rule to implement the GINA protections has been developed and is currently under review as part of a larger omnibus Health Insurance Portability and Accountability Act (HIPAA) privacy and security rule. As the rule has not yet been published, the Department is not in a position to discuss the final policies. However, be assured that in developing the final rule, the Department has been carefully considering the views expressed in response to the proposed rule and the potential impact of the proposed rule on the long-term care market.

*Question.* I would like to follow up with you on an issue I raised in a November 15, 2011 letter I sent to CMS Administrator Berwick along with Senators Schumer, Gillibrand, Casey, and Klobuchar regarding the viability of farmer cooperative-provided health insurance plans under the Affordable Care Act (ACA). As you know, dairy cooperatives have a long history of providing their members with high-quality, low-cost coverage that is specially tailored to the needs of farmers. These plans are very important to me as I helped secure funding to create such plans in my home state of Wisconsin.

As you know, under ACA, only individuals who purchase insurance through the State Exchanges qualify for the advanced premium tax credit. Unfortunately, this creates a financial incentive for thousands of lower-income farmer cooperative members to leave their cooperative-offered plan for the Exchange, which, in turn, would leave the farmer cooperative risk pool severely degraded. This outcome would inevitably lead to higher prices for remaining farmer coop members and is ultimately likely to lead to an elimination of dairy cooperative-sponsored coverage. This would be an unfortunate, and unintended, outcome of ACA, given the important and trusted role that dairy cooperatives play in the lives of their members.

My colleagues and I have been pursuing, along with other groups, including some representatives of organized labor, a proposal to allow for section 1334 of ACA to serve as a mechanism by which nonprofit insurance providers like farmer cooperatives and Taft-Hartley plans, could offer their coverage through the multi-state exchanges, thus allowing for their lower-income members to avail themselves of the advanced premium tax credit. This approach could benefit both interests by providing continued access for cooperative-offered plans and the Taft-Hartley plans while staying within the construct of ACA.

I want to see these efficient, successful, and popular plans continue and ask that you address the issue as soon as possible. Will you look into this important issue and help find a regulatory solution for this unintended problem?

Answer. The Department is considering options to address these concerns. The administration is fully supportive of farmers receiving coverage through these farmer-owned cooperatives and intends to take feasible actions to preserve these organizations as health insurance options for American farmers. Farmers who do not receive such coverage will have access to Exchanges to obtain coverage through a qualified health plan, and may be eligible for premium tax credits and reduced cost-sharing of out of pocket costs. Eligibility for such benefits may depend upon the nature of the coverage available through a farmer-owned cooperative, and the farmer's income.

*Question.* I have been in contact with you and the Food and Drug Administration (FDA) about the FDA's proposed rule to improve pregnancy drug labeling. As you know, an estimated 75 percent of pregnant women use between four to six prescriptions or over-the-counter drugs during their pregnancy. Since 1997, the FDA's Pregnancy Labeling Task Force has worked on updating the pregnancy labeling system and FDA issued proposed rule with revised labeling guidelines in 2008.

In my previous inquiries, you have told me that the drug labeling rule is a priority for the FDA. But the proposed rule has been lingering since 2008. As of today, in March 2012, FDA has not yet issued a final rule governing the labeling of drugs for women during pregnancy. Is FDA planning on issuing the FDA pregnancy rule in 2012? Since this pregnancy rule is a priority for FDA, can you commit to finalizing the rule in 2012?

Answer. FDA is committed to finalizing a rule that will improve drug labeling for women who are pregnant, and we are diligently working to issue this important rule. Because of the complexity of this rule and the time required to review and fi-

nalize this rule, it is not possible to say whether the final rule will publish during 2012.

However, we want to emphasize that, in addition to finalizing the pregnancy and lactation rule, FDA has other important and ongoing projects related to the health of pregnant and lactating women. The Maternal Health Team and other offices in the Center for Drug Evaluation and Research are developing regulations, guidance documents, and procedures related to the use of medicines during pregnancy and lactation. For example, on April 30–May 1, 2012, FDA is holding a “Public Workshop on Developing Animal Models of Pregnancy to Address Medical Countermeasures for Influenza.”

In addition, FDA has issued five scientific guidances relating to pregnancy and lactation that support women’s health:

- Integration of Study Results to Assess Concerns about Human Reproductive and Developmental Toxicities;
- Establishing Pregnancy Exposure Registries;
- Pharmacokinetics During Pregnancy and Lactation;
- Evaluating the Risks of Drug Exposure in Human Pregnancies; and
- Clinical Lactation Studies—Study Design, Data Analysis, and Recommendations for Labeling.

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QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

TITLE X FAMILY PLANNING PROGRAM

*Question.* Federally funded family planning health centers are facing increased demand, with more than 4 in 5 centers reporting an increase in clients who are uninsured and more than two-thirds reporting a decrease in the proportion of clients able to pay the full fee for their services. Not surprisingly but of great concern—1 in 4 women now report having put off a gynecological or birth control visit to save money in the past year. As the rates of uninsured steadily climb and many families lack access to basic healthcare services, these health centers struggle—with severely limited funding—to meet the ever increasing unmet need.

What role do you see title X playing in an environment where increased need and increased costs are stretching women’s health centers resources thin, consequently making it difficult for American families to access their most basic healthcare services?

*Answer.* The Title X Family Planning program continues to play a critical role in ensuring access to high-quality, client-centered, and affordable primary and preventive health services to millions of uninsured and underinsured men, women, and adolescents at more than 4,000 health centers across the United States, including federally qualified health centers, free-standing clinics, hospitals, and State and local health departments. Title X-funded services include contraceptive counseling and related services, physical exams, screening and treatment for sexually transmitted infections, HIV testing, clinical breast exams, and cervical cancer screening. In 2010, 90 percent of clients had incomes at or below 200 percent of the Federal Poverty Level.

In addition to supporting basic healthcare services for about 5 million individuals, the title X program also provides support for the family planning infrastructure across the Nation, including critical support for training and salaries for reproductive health providers. The Title X program also has had a long history of establishing the rules governing the delivery of high-quality family planning services in clinic settings—a role the program will continue to play. The Department of Health and Human Services (HHS) also anticipates that title X centers will remain critical sources of care for vulnerable populations who are uninsured as well as individuals who will be newly insured or Medicaid eligible under the Affordable Care Act (ACA). These centers will play an important role in achieving a key goal of ACA—improving access to affordable preventive healthcare.

While resources have been stretched thin, HHS fully anticipates that the program will continue to provide services through a broad range of community-based providers as well as leverage multiple sources of Federal and State funding, including Medicaid, state family planning dollars where available, the Maternal and Child Health Block Grant, and the Social Services Block grant. Although difficult to predict, it is possible that after the full implementation of the ACA, the payer mix will change at some family planning centers to include a greater share of funding from private insurance and Medicaid. The ACA requires that most private insurance cover certain contraceptive services with no cost-sharing. As demand continues to increase, title X sites will continue to support high-quality services delivered by ex-

perienced clinicians and a solid infrastructure able to address the needs of women, men, and vulnerable populations.

#### CONTRACEPTION

*Question.* According to the Guttmacher Institute, in 2006 only about one-half of the women who needed or wanted publicly funded family planning were able to receive those services, so won't requiring insurance plans to cover contraception help fill a public health gap that publicly funded family planning funding streams are not able to meet?

*Answer.* Before ACA, too many Americans didn't get the preventive healthcare they need to stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce healthcare costs. An estimated 20.4 million women are currently receiving expanded preventive services without cost-sharing because of ACA.

On average, a woman uses contraception for 30 years of her life, with the average cost of contraception at \$50 per month.

By eliminating cost-sharing requirements for certain preventive services under most plans, ACA is improving access to these services. The guidelines for women's preventive services ensure that women have access to a comprehensive set of preventive services and fill the gaps in current preventive services guidelines for women's health. This means that most women will no longer have to pay often burdensome co-payments, co-insurance, and deductibles in order to access necessary preventive services such as contraception, breastfeeding support, and domestic violence screening. By removing coverage barriers, these guidelines will help improve access to comprehensive quality healthcare for all American women.

*Question.* Opponents of insurance plans being required to cover contraception claim that contraception does not actually lower healthcare costs in the long-term, but doesn't every \$1 spent on family planning services stand to save \$4 in pregnancy related healthcare?

*Answer.* Actuaries and experts agree that covering contraception actually saves money for insurance companies. The cost of contraception coverage is low and tends to be more than offset by the savings that result from improved health and fewer unplanned pregnancies. For example:

- A study by the National Business Group on Health estimated that it would cost employers 15–17 percent more not to provide contraceptive coverage in employee health plans than to provide such coverage, after accounting for both the direct medical costs of pregnancy and indirect costs such as employee absence and reduced productivity.
- When contraceptive coverage was added to the Federal Employees Health Benefits Program, premiums did not increase.
- Fifteen States including Pennsylvania have family planning demonstration programs under Medicaid that have significantly expanded coverage of these services without increasing State or Federal costs.

#### NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH'S SPOKANE RESEARCH LABORATORY

*Question.* As you know, the work conducted at the National Institute for Occupational Safety and Health's (NIOSH) Spokane Research Laboratory is vital to maintaining and improving the health and safety of workers in industries including metal and nonmetal mining throughout the Western United States. Over the last 3 years, the Spokane Research Laboratory has undergone internal reorganization that could lead to the Laboratory's closure, which would greatly impact the health and safety of Western United States miners. As one of NIOSH's lowest-cost laboratories, the work done at the Spokane Research Laboratory is also conducted at a value to taxpayers.

What plans do you have to continue the critical work of Western United States mine health and safety research at the Spokane Research Laboratory?

*Answer.* NIOSH continues to address the priority needs of all coal, metal, and nonmetal mineworkers, including those working at mines located in the Western United States through its national mining safety and health research program. The Office of Mine Safety and Health Research (OMSHR) maintains staff in Spokane, Washington and Pittsburgh, Pennsylvania who are assigned to the full range of projects in their research portfolio, and OMSHR plans to continue serving the needs of all of its customers and stakeholders through the work of staff at both the Spokane and Pittsburgh campuses.

*Question.* Will you provide me with the Spokane Research Laboratory's fiscal year 2009–2013 budget allocations for staff/personnel, including full-time equivalent employee levels; and facilities maintenance and construction?

Answer.

NIOSH Spokane	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011	Fiscal year 2012	Fiscal year 2013
FTE .....	50	50	45	38	36
Personnel costs .....	\$5,384,634	\$5,444,656	\$4,926,490	\$4,142,030	\$3,942,030
Facilities maintenance/construction costs .....	\$601,335	\$480,330	\$689,559	<sup>1</sup> \$2,607,462	\$757,462

<sup>1</sup> Fiscal year 2012 includes one-time funding (\$1.85 million) to install a new fire suppression system in the Spokane facility.

The CDC's Web site states that its mission is to: ". . . collaborate to create the expertise, information, and tools that people and communities need to protect their health," and that this mission is to be accomplished by working with partners to ". . . detect and investigate health problems, and conduct research to enhance prevention." The CDC follows this mission statement with a pledge to the American people that includes a commitment to: "base all public health decisions on the highest quality scientific data, openly and objectively derived."

*Question.* How does the CDC plan to fulfill its mission and maintain their pledge to the American people to "base all public health decisions on the highest quality scientific data" within the area of workplace safety if they have eliminated funding for the Education and Research Centers and the National Occupational Research Agenda's Agricultural, Forestry, and Fishing Programs?

Answer. The fiscal year 2013 budget eliminates the Education and Research Centers and the Agricultural, Forestry, and Fishing Sector of the National Occupational Research Agenda because in a resource-constrained environment, these programs are a lower priority relative to other CDC programs.

When NIOSH's Education and Research Centers were originally created almost 40 years ago, there were a limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. Now, many schools of public health include coursework and many have specializations in these areas. CDC will continue to provide technical assistance to the Education and Research Centers despite the proposed elimination of grant funding.

The Agricultural, Forestry and Fishing Sector, when compared to other CDC programs, is considered lower-priority in terms of CDC's core mission and its ability to have a national impact on improved health outcomes. In fiscal year 2013, CDC will focus on other sectors of research within the National Occupational Research Agenda to promote widespread adoption of improved workplace safety and health practices based on research findings.

#### QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

##### EXCHANGES

*Question.* As you said in your testimony, fiscal year 2013 will be a critical year for building the infrastructure and initiating the many business operations that are vital for the exchanges to begin operating in 2014.

I understand that your agency has been working hard to build out the Federal exchanges in States that have officially declared that they are not intending to partner with Federal Government on this issue. As you know, Louisiana is one of these States.

I want to stress to you how important it is to me, and to the people of Louisiana, that we have a strong exchange in our State. I stand by ready to assist you in creating a high-functioning Federal exchange in Louisiana.

In the absence of partnership from State government, it will be very important to work with other stakeholders in Louisiana, such as consumer groups and providers, to ensure that the Federal exchange is as robust as possible.

My question is: what plans does HHS have for engaging with nongovernment stakeholders and advocates within the States, particularly in States where the State government declines to partner with the Federal Government on this important issue?

Answer. HHS is working diligently with our Federal and State partners to ensure Affordable Insurance Exchanges are available to all Americans by January 2014. Much of the needed infrastructure work will occur in 2012, and beginning in 2013, major business processes will become operational in anticipation of open enrollment in October 2013.

HHS is committed to the successful implementation of the Federally Facilitated Exchanges (FFE's). The FFE's will coordinate with many State experts, including

State Medicaid Agencies related to eligibility for insurance affordability programs, State Departments of Insurance related to certification and oversight of qualified health plans, and the State Governor's offices for intergovernmental affairs. The FFEs will also coordinate with nongovernment stakeholders such as the insurance community—beyond those offering qualified health plans—when operating Reinsurance and Risk Adjustment, and consumer groups who can help us understand each State's unique characteristics and challenges. We will provide more information about our plans to engage nongovernment stakeholders once we have a complete understanding of which States plan to implement their own Affordable Insurance Exchanges and which States plan to participate in the FFEs.

#### HEALTH CENTERS

*Question.* Last August, the Health Resources and Services Administration (HRSA) announced the winners of the New Access Point grant. There were a total of 67 awards announced throughout the country.

I was very concerned that not a single applicant from Louisiana was chosen to receive the award, despite the demonstrated competency of many of the applicants and the clearly established need for community health services throughout our state. The absence of additional New Access Point grantees in our State leaves many of our non-federally qualified health centers (FQHCs) without the resources they need to meet the needs of their community.

The President's fiscal year 2013 request includes \$3 billion for health centers, including an additional \$300 million in mandatory money from the Affordable Care Act (ACA). You say that this money will provide 240 New Access Points.

I will work to help ensure you receive the money your agency needs to fund these New Access Points, and I urge you to carefully consider all qualified applications from all States, particularly those that did not receive any awards in fiscal year 2012.

*Answer.* As you know, the funding for fiscal year 2011 Health Center New Access Points was extremely competitive. In fiscal year 2011, HHS received 810 applications and funded 67 grants. In fiscal year 2012, HHS anticipates that up to \$145 million will be available to support approximately 220 new access points grants. The funding will support the fiscal year 2011 approved but unfunded applications following the rank order list consistent with statutory health center requirements to make awards for fiscal year 2012. The fiscal year 2011 applicants will be required to submit information in March to verify continued eligibility for a New Access Point award. HHS anticipates making awards in June or July 2012. In addition, HHS anticipates awarding \$20 million to support Beacon Communities long-term improvements in quality of care, health outcomes and cost efficiencies; \$43 million for technical assistance to enhance the operations and performance of health centers, and \$5 million for HIV/AIDS services to support enhanced HIV/AIDS treatment.

In fiscal year 2013, the budget includes \$19 million to establish approximately 25 new access points. These grants will support new full-time service delivery sites for the provision of comprehensive primary and preventive healthcare services to approximately 150,000 additional people.

#### NIH—IDEA PROGRAM

*Question.* The National Center for Research Resources (NCRR), an institute within the National Institutes of Health (NIH), houses a program called the Institutional Development Award (IDeA program).

The IDeA program funds research in states that are traditionally underrepresented within the NIH, including Louisiana.

In the fiscal year 2012 HHS budget, the Congress increased the funding for the IDeA program by \$46 million. However, for the fiscal year 2013 budget year, the President proposes a \$48 million decrease. It appears that this money is being taken away in order to help fund the new National Center for Advancing Translational Sciences (NCATS).

At a time when NIH budgets are flat, and when the most heavily funded States will continue to be funded as they always have, why would the administration propose reducing the one pot of money that is specifically designed for States that have traditionally been underfunded?

*Answer.* For fiscal year 2012, the IDeA program was provided with a 21-percent increase in the congressional appropriation, or approximately \$50 million, in funding over fiscal year 2011, while most other NIH programs were held relatively flat. For fiscal year 2013, the budget proposes \$225 million for the IDeA program, about the same as the fiscal year 2011 level, and approximately \$50 million below fiscal year 2012. The IDeA program is valued by NIH and gives many investigators at

less research-intensive institutions an opportunity to contribute to biomedical research. Within a constrained budget environment, NIH believes that the IDeA program should not be treated differently than most other programs in the fiscal year 2013 NIH budget which are flat with fiscal year 2011. With regard to NCATS, the fiscal year 2013 budget requests an increase because of the need for innovative solutions to the bottlenecks currently in the development pipeline that hinders the movement of basic research findings into new diagnostics and therapeutics for patients. The request for IDeA is made in the context of the total NIH budget and not as a particular offset to any one program or line item.

#### LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

*Question.* I was dismayed to see that the budget again asks for another cut to Low-Income Home Energy Assistance Program (LIHEAP). Because of the way the LIHEAP law is written, warm weather States, growth States, and States experiencing high-energy prices don't receive a fair share of the funding except for that portion of Base grant appropriations more than the \$2 billion mark.

With an estimated 825,000 living in poverty, Louisiana has the second-highest poverty rate in the nation. Although 75,000 households were helped by LIHEAP in 2011, it is possible that only about 52,000 can be reached under the fiscal year 2013 budget request. High summer temperatures are life-threatening especially to the at-risk populations we expect LIHEAP to help, and last summer was one of the hottest on record.

I am concerned that further reducing LIHEAP imperils Louisiana households with seniors, disabled, and preschoolers. I believe the core of this program needs to be much better funded if these most vulnerable of children and families are to be given a fair shot at their potential.

Please provide the subcommittee with the latest-available State-by-State estimates of the LIHEAP-eligible populations that cannot be met at the requested funding level. I recognize that such estimates are inherently imprecise, but believe they would nonetheless greatly help our decisionmaking and understanding.

*Answer.* I understand your concern about the responsiveness of LIHEAP to cooling costs in States like Louisiana. While the Congress did not provide contingency funds in fiscal year 2012, the fiscal year 2013 President's budget does include \$200 million giving us the ability to respond to weather or other emergencies.

The impact of the fiscal year 2013 request level on the number of LIHEAP-eligible households unserved by the program depend on a number of factors including the impact of the economy on the number of poor households, and State-level decisions on eligibility and payment levels. The number of households served is also affected by contributions from other sources including utility companies and good neighbor funds. For example, in fiscal year 2008, the most recent year where we have complete data, there were roughly 33.5 million LIHEAP eligible households. With an appropriation of \$2.57 billion, the program served an estimated 5.4 million households with heating assistance and an estimated 500,000 households with cooling assistance.<sup>1</sup> The most recent data, from special tabulations of the Census Bureau's 2010 American Community Survey which is based on a national sample of households, indicates that the number of LIHEAP-eligible households increased to 37.1 million in fiscal year 2010. Preliminary fiscal year 2010 program data shows that with an appropriation of \$5.1 billion, the program provided heating assistance to 7.4 million households, cooling assistance to 900,000 households, and crisis assistance (both heating and cooling) to 2.3 million households. The fiscal year 2013 President's budget includes \$3.02 billion for LIHEAP, a 17-percent increase more than fiscal year 2008 enacted and last year's budget request. Unfortunately, there are too many variables to estimate how the additional funding will affect the percentage of eligible households receiving LIHEAP in fiscal year 2013.

#### SCHOOL-BASED HEALTH CENTERS

*Question.* School-based health centers (SBHCs), a program that you have voiced your support for on numerous occasions, was not funded in the administration's fiscal year 2013 budget.

Understanding that SBHCs are a vital safety net provider for our school-aged children across the country and a federally authorized program, can you please inform the subcommittee of your plans for funding the SBHC authorization for the 2014 fiscal year?

<sup>1</sup> See the following link for State-level information: [http://www.acf.hhs.gov/programs/ocs/liheap/publications/FY08\\_congressional\\_state\\_data.html#TableIII2](http://www.acf.hhs.gov/programs/ocs/liheap/publications/FY08_congressional_state_data.html#TableIII2)

In addition, would you offer some examples on how the administration will support community health centers looking to form partnerships with school districts and local health departments that currently operate SBHCs within the service area of the community health center?

Answer. ACA appropriated \$200 million from fiscal year 2010–2013 to address capital needs, including new construction, alteration/renovations and equipment-only projects, to improve delivery and support expansion of services at school-based health centers. While funds have only been provided for the capital grants, experience has demonstrated that capital funding can significantly expand service delivery. In addition, SBHCs may apply for the Community Health Center New Access Point funding to support new healthcare service delivery sites, if they meet the health center program eligibility criteria. HRSA will continue to offer technical assistance to communities interested in developing partnerships and formal affiliations that support the provision of primary healthcare to underserved populations, including school-aged children. Priorities for the fiscal year 2014 budget are in the preliminary stages of development. Programs with existing authorizations will be given appropriate consideration in the context of the total agency budget formulation process, including the SBHC program.

CENTERS FOR DISEASE CONTROL AND PREVENTIONS CHRONIC DISEASE PROGRAM  
CONSOLIDATION

*Question.* Would you please tell me specifically how the Coordinated Chronic Disease Prevention and Health Promotion program will be structured and how the funding for the components of the consolidation will operate?

Answer. The budget includes \$379 million, an increase of \$129 million more than fiscal year 2012, for the Coordinated Chronic Disease Prevention program. This program consolidates disease-specific chronic disease funding into a comprehensive program to address the leading chronic disease causes of death and disability, including heart disease and stroke. Because many inter-related chronic disease conditions share common risk factors, the new programs will improve health outcomes by coordinating the interventions that can reduce the burden of disease and disability. Programmatic activities that advance prevention and control of each disease will focus on epidemiology and surveillance, environmental interventions that promote healthful behaviors, work with the healthcare system to more effectively deliver quality clinical and other preventive services, and community-clinical supports for lifestyle interventions for those living with or at high risk of developing chronic conditions.

The proposed structure and funding for the Coordinate Chronic Disease Prevention and Health Promotion program will be operationalized through a new 5-year cooperative agreement cycle. Funding will be allocated to States, tribes, and territories on a formula and competitive basis. Approximately one-third of grant funding will be formula based and the remaining two-thirds will be allocated competitively.

Specific components of the proposed fiscal year 2013 program include:

- Core, formula-based awards of approximately \$82 million to State, tribal, and territorial health departments based on population size and chronic disease burden. Allocations for States will be based on a combination of population and poverty level. Poverty and chronic disease are closely related factors. This proposed allocation methodology is similar to the allocation formula used for the fiscal year 2011 Coordinated Chronic Disease grant program. The proposed formula-based allocation methodology for eligible tribal entities and territorial health departments will include a base amount and an increment based on population size. Core formula-based funding will build and strengthen State health department capacity and expertise to effectively prevent chronic disease and promote health. This capacity and expertise includes:
  - Ensuring that every State has a strong foundation to support chronic disease prevention and health promotion;
  - Maximize the reach of categorical chronic disease programs in States by leveraging shared basic services; and
  - Provide leadership and expertise to work in a coordinated manner across chronic disease conditions and risk factors to most effectively meet population health needs, particularly for populations with the greatest health disparities.
- Competitive awards of approximately \$16 million to State, tribal, and territorial health departments for specific chronic disease prevention and health promotion interventions, including:
  - Strategies that support and reinforce healthful behaviors and expand access to healthy choices;

- Health systems interventions to improve the delivery and use of clinical and other preventive services, such as blood pressure control, appropriate aspirin use, and cancer screenings; and
- Community-clinical linkage enhancement to better support chronic disease self-management.
- The remaining funding will support:
  - Competitive awards to national organizations, national networks, and other entities to disseminate best practices and effective interventions; and
  - CDC's national chronic disease subject matter expertise; technical assistance to grantees; national program surveillance; evaluation and research activities; and program leadership.

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QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

CONGENITAL HEART DISEASE

*Question.* Congenital heart disease (CHD) is one of the most prevalent birth defects in the United States and a leading cause of birth defect-associated infant mortality. Due to medical advancements more individuals with congenital heart defects are living into adulthood, unfortunately, our Nation has lacked a population-surveillance system across the life-course for CHD. The healthcare reform law included a provision, which I authored, that authorizes the Centers for Disease Control and Prevention (CDC) to expand surveillance and track the epidemiology of CHD across the life-course, with an emphasis on adults. The Consolidated Appropriations Act of 2012 provided the CDC with \$2 million in new funding for enhanced CHD surveillance. Please describe how CDC is using this funding. It is my understanding that some funding will go toward pilot projects and an interdisciplinary expert meeting. Please summarize the status of these initiatives and how they will advance CHD surveillance and improve our understanding of CHD and the disease's prevalence across subgroups (including age and race/ethnicity). If additional money is appropriated for CHD surveillance in fiscal year 2013, how would that funding be utilized?

*Answer.* In fiscal year 2012, CDC plans to provide support through cooperative agreements for CHD surveillance activities and to support a meeting of experts on CHDs across the lifespan. CDC developed a new funding opportunity announcement for CHD surveillance focused on adolescents and adults, which is planned for publication in May 2012. The purpose is to provide support through cooperative agreements for the development of robust, population-based estimates of the prevalence of CHDs focusing on adolescents and adults and better understand the survival, healthcare utilization, and longer-term outcomes of adolescents and adults affected by CHDs. CDC anticipates funding 3 to 4 pilot sites. This is planned as a 3-year cooperative agreement, and preliminary data is anticipated after 2 years of funding.

Also, CDC plans to support a meeting of experts on CHDs across the lifespan. This meeting will provide critical input to assist CDC in developing a public health research agenda for CHDs, and improve CDC's capacity to have a measurable public health impact on the lives of those with CHDs.

For the CHD expert meeting, CDC has formed a steering committee and developed a draft invitation list. The steering committee includes CDC and the National Institutes of Health (NIH) representatives, pediatric cardiologists, and adult CHD specialists. The steering committee has developed a list of potential invitees including pediatric cardiologists, adult CHD specialists, epidemiologists, economists, health services researchers, and other areas of expertise to guide the development of a prioritized public health research agenda for CHDs. The meeting is tentatively scheduled for September 10–11, 2012 and will be held at CDC's main campus in Atlanta, Georgia.

If additional funding is available in fiscal year 2013, CDC would provide supplements to existing pilot sites and enhance other ongoing activities based on the CHDs public health research agenda formulated by the CHD steering committee.

*Question.* There continue to be higher rates of mortality and serious disability at all ages among people with congenital heart disease compared to the general population. Could you please describe current efforts at Agency for Healthcare Research and Quality (AHRQ) and NIH to better understand healthcare utilization and treatment outcomes for congenital heart disease across the life-span?

*Answer.* AHRQ's research related to congenital heart disease focuses mainly on pediatric issues. This includes supporting the Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program. While AHRQ has not yet developed specific measures of the quality of care for children with heart

disease, congenital heart disease is a major birth defect and a major cause of infant morbidity and mortality. Therefore its care can be significantly impacted by various measures, including those that will track:

- global pediatric patient safety;
- child hospital readmissions;
- neonatal costs, quality, and outcomes;
- neonatal and pediatric intensive care unit quality and outcomes;
- patient-reported outcomes and inpatient experiences of care; and
- identification of, and coordination of care for children with special healthcare needs.

AHRQ is also developing and supporting its Healthcare Cost and Utilization Project (HCUP), most notably the Kids' Inpatient Database (KID). KID is a unique and powerful database of hospital inpatient stays for children. It was specifically designed to permit researchers to study a broad range of conditions and procedures related to child health issues. KID includes data on volumes, costs, and charges of inpatient pediatric cardiac care. Researchers and policymakers can use KID to identify, track, and analyze national trends in healthcare utilization, access, charges, quality, and outcomes. For example, researchers at Children's Hospital Boston used KID data to examine factors associated with increased resource utilization for children with congenital heart disease. Furthermore, AHRQ is developing Pediatric and Inpatient Quality Indicators that include measures of procedure volume and risk-adjusted mortality following pediatric cardiac surgery. It is also supporting a contract on the prevention of Staph aureus infections in cardiac surgical patients, including adult survivors of congenital heart disease.

Within NIH, the National Heart, Lung, and Blood Institute (NHLBI) has made a significant investment in answering these important questions through support of targeted programs as well as a large portfolio of investigator-initiated grants. The Bench to Bassinet (B2B) program supports an extensive collaboration among multidisciplinary investigators to improve outcomes for patients with congenital heart disease.<sup>1</sup> Its longest-standing component is the Pediatric Heart Network (PHN) which conducts multicenter research in congenital heart disease.<sup>2</sup>

A major focus of PHN studies has been on the short- and long-term outcomes of medical and surgical interventions. One trial found that the initial surgical strategy typically used for infants with only a single functional heart-pumping chamber may improve short-term, but not intermediate-term, outcomes. The wealth of data obtained in this surgical study also allowed us to examine the considerable variation in medical care practice that existed across the 15 major academic centers that participated. Further analysis of this information is expected to shed light on how such variations affect outcomes and costs. Another PHN trial found that a commonly prescribed drug, enalapril, had no effect on outcomes. A follow-up study is now assessing whether this result has altered prescribing patterns in North America. An ongoing follow-up of a cohort of adolescents who have undergone staged surgical repair for single ventricle physiology is enabling us to examine the critical transition from pediatric to adult care. This transition has proven challenging for many who have serious CHD; appropriate care in adulthood is essential to optimizing their independence and function.

Another B2B component is a consortium studying the genetic underpinnings of congenital heart disease outcomes. In the initial 15 months, it has recruited some 3,000 children and adults (more than 20 percent are older than 18 years of age), along with many of their parents, to study both genetic causes of congenital heart disease and genetic contributions to treatment outcomes. Tetralogy of Fallot (a "blue-baby" defect), for instance, can result from at least 6 different genetic mutations. Once we know how the mutations influence outcomes, we will be able to risk-stratify patients for more- or less-intensive treatment and to offer personalized therapies.

NHLBI is funding the Pumps for Kids, Infants, and Neonates (PumpKIN) program to design, develop, test, and make available to infants and young children a number of advanced circulatory support devices for congenital and acquired cardiovascular disease resulting in heart failure.<sup>3</sup> Currently, very few options exist for these vulnerable heart failure patients. The program includes two small implantable ventricular assist devices based on the latest technologies and two advanced integrated and compact extracorporeal membrane oxygenator systems. They have been designed to address troublesome shortcomings of circulatory support devices for children such as reliability, biocompatibility, infection, thrombosis, and size. The four

<sup>1</sup> <http://www.benchtobassinet.org/>

<sup>2</sup> <http://www.pediatricheartnetwork.com/>

<sup>3</sup> <http://public.nhlbi.nih.gov/newsroom/home/GetPressRelease.aspx?id=2689>

devices are in their last phases of bench-testing, with clinical trials expected to begin in October 2013. In contrast to older adults, for whom these devices may be definitive therapy, these devices are used in children as bridges to transplantation. The shortage of appropriate hearts for transplantation into children requires that better devices be available to support patients until a donor heart is available.

NHLBI also funds a number of grants that address common issues faced by children and adults with congenital heart disease, such as exercise capacity, problems with neurological function and learning, and overall quality of life. These investments are aimed to ensure a brighter future for people of all ages with congenital heart disease.

#### CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION

*Question.* The administration proposes cutting the Children's Hospitals Graduate Medical Education (CHGME) program by two-thirds to \$88 million in fiscal year 2013. As you know, this program supports training of pediatric providers at two freestanding children's hospitals in Illinois—Children's Memorial and La Rabida Children's Hospital—and approximately 50 others around the country. The CHGME recipient hospitals train more than 5,600 full-time equivalent residents annually.

I am concerned by the proposed cut to CHGME funding. Through Medicaid and the Children's Health Insurance Program, we've expanded the number of children with insurance coverage in the United States. I view this as a great success, however we must ensure we have an adequate supply of physicians to care for these children.

Already, there are significant shortages in several pediatric subspecialties, including neurology, developmental-behavioral medicine, general surgery, and pulmonology, that are affecting patient care. A survey last year by the National Association of Children's Hospitals and Related Institutions found wait times of more than 10 weeks to see a pediatric endocrinologist, and 9 weeks for a pediatric neurologist.

Is the administration concerned that reducing CHGME funding will worsen the shortage of pediatric subspecialists and affect children's access to care by general pediatricians?

*Answer.* We recognize the vital role that children's hospitals and pediatric providers play in providing quality healthcare to our Nation's children. The fiscal year 2013 CHGME funding level continues to support direct costs for training pediatric residents at independent children's hospitals. This payment provides support for resident salaries, expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, cost associated with providing the GME training program, and allocated institutional overhead costs.

The fiscal year 2013 budget retains the incentive to maintain total resident levels. The administration recognizes that research has indicated that there is a significant shortage of pediatric subspecialists, resulting in children with serious illnesses being forced to travel long distances—or wait long periods—to see a pediatric specialist. In response to these shortages, the fiscal year 2013 President's budget includes \$5 million to implement the Pediatric Specialty Loan Repayment (PSLR) program that was authorized in the Affordable Care Act (ACA). Under this program, loan repayment agreements will be authorized for pediatric specialists who agree to work in underserved areas.

While both the CHGME Payment and the PSLR programs support the pediatric medical workforce, the focus of each is different. The CHGME Payment Program serves the purpose of providing residency training in Children's Hospitals through the payments made to Children's Hospitals, while the PSLR program is designed to assist pediatric specialists more directly and increase the number of pediatric specialists in underserved areas.

#### SECTION 317 IMMUNIZATION PROGRAM

*Question.* The Section 317 Immunization Program helps to ensure high immunization coverage levels and low incidence of vaccine preventable diseases by supporting state and local immunization programs in planning, developing, and maintaining a public health infrastructure. The administration's budget proposes a \$58 million cut to the section 317 program. Will this reduction impact the agency's ability to purchase grants or operational support for health departments? How do you see the role the section 317 program evolving with the implementation of ACA? The President's budget proposes transferring \$72 million from the Prevention and Public Health Fund to the section 317 program. How would those funds be used?

*Answer.* The fiscal year 2013 budget request includes funds for vaccine purchase to continue outreach to the hardest-to-serve populations, and critical immunization

operations and infrastructure that supports national, State, and local efforts to implement an evidence-based, comprehensive immunization program. The request also specifically directs \$25 million toward continuation of the billables project, which allows public health departments to vaccinate and bill for fully insured individuals in order to maintain section 317 vaccines for the most financially vulnerable and respond to time-urgent vaccine demands, such as outbreak response. The fiscal year 2013 budget will sustain the national immunization program vaccine purchase and immunization infrastructure. The budget does not continue funding for one-time enhancements planned for fiscal year 2012 to modernize the immunization infrastructure through funding to the grantees for improving immunization health IT systems and vaccine coverage among school-age children and adults; expansion of the evidence base for immunization programs and policy; and enhancements to national provider education and public awareness activities to support vaccination across the lifespan.

ACA requires new health plans to cover routinely recommended vaccines without cost-sharing when provided by an in-network provider. As these health insurance reforms expand prevention services to more Americans, the size of the population currently served by section 317 vaccine is expected to decrease in size, specifically underinsured children. The Section 317 Immunization Program will continue to have a critical role in:

- providing vaccines to meet the needs of uninsured adults and responding to urgent vaccine needs such as outbreak response; and
- ensuring the necessary infrastructure is in place to support the Nation's immunization system for both routine vaccination as well as managing vaccine shortages and other emergency response.

This critical infrastructure serves both the public (e.g., Vaccines For Children Program and Section 317) and private sectors. Insurance coverage alone will not provide the immunization infrastructure necessary to ensure a strong evidence base for national vaccine programs and policy, quality assurance for immunization services, and high-vaccination coverage rates across the lifespan.

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#### QUESTIONS SUBMITTED BY SENATOR JACK REED

##### SECTION 317 (IMMUNIZATIONS)

*Question.* The Centers for Disease Control (CDC), in its fiscal year 2011 report to the Congress on the Section 317 Immunization Program estimated that approximately \$1.72 billion is necessary to fulfill the goals of adequately immunizing uninsured and underinsured children, adolescents, and adults. Indeed, vaccination programs have been proven to be one of the most cost-effective approaches to reducing disease and future healthcare costs, a critical goal of the Congress. However, the fiscal year 2013 budget proposal contains a nearly 10-percent cut to this program. While millions more uninsured and underinsured individuals will receive free vaccinations beginning in 2014, how does this funding level ensure the cost-effective immunization programs currently in place are maintained during the intervening years?

*Answer.* The fiscal year 2013 budget request includes funds for vaccine purchase to continue outreach to the hardest-to-serve populations, and critical immunization operations and infrastructure that supports national, State, and local efforts to implement an evidence-based, comprehensive immunization program. The request also specifically directs \$25 million toward continuation of the billables project, which allows public health departments to vaccinate and bill for fully insured individuals in order to maintain section 317 vaccines for the most financially vulnerable and respond to time-urgent vaccine demands, such as outbreak response. The fiscal year 2013 budget will sustain the national immunization program vaccine purchase and immunization infrastructure. The budget does not continue funding for one-time enhancements planned for fiscal year 2012 to modernize the immunization infrastructure through funding to the grantees for improving immunization health IT systems and vaccine coverage among school-age children and adults; expansion of the evidence base for immunization programs and policy; and enhancements to national provider education and public awareness activities to support vaccination across the lifespan.

##### LEAD POISONING PREVENTION

*Question.* The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) recently recommended reducing the blood lead level in children from 10ug/dL to 5 ug/dL when greater medical monitoring is necessary, along with en-

hanced lead education for family members and more comprehensive investigations of the child's environment. What is CDC's plan for implementing this recommendation?

Answer. The ACCLPP recommendations are currently being reviewed and evaluated by U.S. Department of Health and Human Services (HHS). The process of carefully reviewing ACCLPP's recommendations and deciding whether or not to concur with them may take several months to complete.

*Question.* In fiscal year 2012, the Congress requested the CDC and Health Resources and Services Administration (HRSA) work together to expand healthy housing activities as part of its Home Visiting Programs and provide greater incentives for States to implement programs that already include these activities. What action has been taken to respond to this request?

Answer. CDC and HRSA are working to identify possible solutions for integrating childhood lead poisoning prevention activities into routine services of HRSA's early childhood Home Visiting Program.

#### HEALTHY HOME AND COMMUNITY ENVIRONMENTS

*Question.* The fiscal year 2013 budget proposes a consolidation of the CDC Healthy Homes and Lead Poisoning Prevention Program and the Asthma Control Program even though the two programs are distinctly different in their mission and activities. Grantees of the Healthy Homes and Lead Poisoning Prevention Program reduce injuries at home, make aging in place a real option for our seniors, prevent radon-caused lung cancer and carbon monoxide poisoning, and sustain efforts to prevent and treat childhood lead poisoning. The Asthma Control Program provides grantees with resources to offer workforce and professional development for asthma prevention and care and self-management, and help improve asthma management in schools, child care centers, and homes. Given the distinctions in these activities, how does CDC plan to consolidate these programs into one while ensuring we don't lose any ground on our lead poisoning prevention and asthma care efforts?

Answer. The fiscal year 2013 budget proposes a new program—Healthy Home and Community Environments—that will incorporate the National Asthma Control Program (NACP) and the Healthy Homes/Lead Poisoning Prevention Program (HHLPPP). The fiscal year 2013 request for the Healthy Homes and Community Environments program is \$27.3 million.

The Healthy Home and Community Environments program is a new, multi-faceted approach to address healthy homes and community environments through surveillance, partnerships, and implementation of science-based interventions to address the health impact of environmental exposures in the home and to reduce the burden of disease through comprehensive asthma control. This integrated approach aims to control asthma and mitigate health hazards in homes and communities such as air pollution, lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, unsafe drinking water, and the absence of smoke and carbon monoxide detectors.

#### TITLE VII (HEALTH PROFESSIONS)

*Question.* The administration's fiscal year 2013 request proposes eliminating the Title VII Health Careers Opportunity Program (HCOP), and suggests that "other federally funded health workforce development programs will continue to promote training of individuals from disadvantaged backgrounds." Can you please provide specific examples of Federal programs other than HCOP that prepare underrepresented minorities to become more competitive applicants to health professions schools? If the program is eliminated, where could aspiring health professionals find the HCOP-offered academic, financial, and mentorship opportunities designed to build a more diverse healthcare workforce commensurate with the Nation's needs?

Answer. The President's budget prioritizes funding activities that have a more direct impact on expanding the primary care workforce by supporting students who have committed to and are training as health professionals. Investments initiated in the fiscal year 2013 budget will train an additional 2,800 primary care providers over the next 5 years.

Other federally funded health workforce development workforce programs will continue to promote training of individuals from disadvantaged backgrounds and increase the likelihood that disadvantaged students are able to attend health professions programs through recruitment activities and scholarship opportunities. For example, the fiscal year 2013 budget includes \$22.9 million for the Centers of Excellence program to recruit, train, and retain underrepresented minority students and faculty in healthcare fields to increase the supply and quality of underrepresented minorities in the health professions. In addition, the fiscal year 2013 budget in-

cludes \$47.5 million for the Scholarships for Disadvantaged Students Program which provides grants to health professions and nursing schools for use in awarding scholarships to financially needy students from disadvantaged backgrounds. This program aims to increase the diversity of the health professions workforce as well as to increase the number of primary care providers working in medically underserved areas. The Affordable Care Act also provided \$85 million in funding for demonstration projects to address health profession workforce needs.

Increasing the diversity of the health professions workforce is an area of focus for HRSA's health professions programs and for the most recent academic year, 58 percent of the graduates from HRSA-funded programs were disadvantaged and/or underrepresented minorities (URM). Similarly, the proportion of NHSC Scholarship Program participants who are underrepresented minorities exceeds the average national enrollment rates for URMs in health professions disciplines. Other examples of programs that support diversity in the health professions workforce are the Primary Care Training and Enhancement and the Nursing Workforce Diversity programs. Grantees in the Primary Care Training and Enhancement program must put a plan in place to increase the number of diverse health professionals and must document their progress. Grantees under the Nursing Workforce Diversity program work to increase educational opportunities for disadvantaged individuals pursuing nursing degrees.

#### STATE CANCER REGISTRIES

*Question.* Given the fact that pediatric cancers are typically fast-growing and require prompt treatment, the Committee has provided funding to assist States with improving data collection and facilitating early case capture of pediatric cancers. This funding has enabled researchers in nine States to more rapidly report childhood cancer occurrences, reoccurrences, and treatments provided to State cancer registries, and 35 States with supplemental registry infrastructure funding. What is the range of technology that States have implemented designed to improve childhood cancer surveillance and facilitate early case capture?

*Answer.* Through CDC's National Program of Cancer Registries (NPCR), the Caroline Pryce Walker Conquer Childhood Cancer Act supports pediatric cancer research, including early case capture. Representing 96 percent of the population, data from NPCR are vital to understanding the Nation's cancer burden and are fundamental to cancer prevention and control efforts at the national, State, and local level.

CDC received funding to support pediatric cancer research in fiscal year 2010 and fiscal year 2011. Fiscal year 2010 resources were used to support supplemental grants to 35 cancer registries with existing electronic reporting activities to expand their work. During fiscal year 2011, CDC allocated funding to specific State projects, where resources could be concentrated to develop comprehensive approaches to pediatric cancer rapid reporting by healthcare providers. CDC awarded funding to seven States.

The seven States funded by CDC to facilitate early case capture of pediatric cancers are building upon existing cancer registry infrastructure and implementing a number of innovative technological approaches to rapid reporting. Some of these include:

- Electronic pathology reporting, which provides real-time, automated reporting to State central cancer registries from various sources, such as hospital pathology laboratories; in-State and out-of-State independent pathology laboratories; and large, out-of-State children's hospitals.
- Electronic reporting from State Health Information Exchanges.
- Using Electronic Health Record data.
- Using electronic reporting of diagnostic imaging to capture cancer cases that do not have a pathology report, such as clinically diagnosed brain tumors.
- Using web-based technology to capture hospital discharge data to ensure that reported information is complete.

As a result of these technological advancements to improve reporting speeds and facilitate data access, researchers will be able to use more timely cancer data—improving research on pediatric cancer trends, risk factors, and treatments. Finally, CDC is working to identify technological methods to streamline data access for researchers by facilitating data linkages and assisting researchers in managing the process to access cancer registry data.

## QUESTIONS SUBMITTED BY SENATOR MARK PRYOR

*Question.* I appreciate the tough decisions your Department has to make as we work to achieve a budget which begins to get our national debt under control. However, I am concerned about the cuts recommended to the Low-Income Home Energy Assistance Program (LIHEAP). The administration's recommendation of \$3 billion represents a 40-percent cut since fiscal year 2010. Since only \$400 million of this will go into the Tier 2/Tier 3 formulas, the low-income citizens of warm weather and growth States will see a marked decrease in their ability to get help.

Unfortunately, America's most vulnerable citizens are concentrated in warm weather States, where they face the growing danger of high summer temperatures. Arkansas's poverty rate of 18.8 percent is the third highest in the Nation. Under the fiscal year 2013 budget request for LIHEAP, it appears that one-third fewer households will be able to receive assistance from LIHEAP this year as compared to 2011.

At a time when LIHEAP is needed the most, I am concerned that this program is proposed to be cut again, and that Americans with little recourse should be denied access to LIHEAP. How can we work together to ensure that the needs of this segment of the population are met?

*Answer.* The Department of Health and Human Services (HHS) is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. To do this, HHS makes investments where they will have the greatest impact and lead to meaningful gains in health and opportunity for the American people.

Our fiscal year 2013 budget request includes a number of investments which support America's most vulnerable citizens. The budget supports critical reforms in Head Start and a Child Care Initiative that, when taken together with the Race to the Top Early Learning Challenge, are key elements of the administration's broader education reform agenda. The budget also includes additional funds to provide incentives to States to improve outcomes for children in foster care and for children at risk of foster care placement.

The request for LIHEAP is \$3.02 billion, \$452 million less than the fiscal year 2012 enacted level, but \$450 million (17 percent) above both fiscal year 2008 and the 2012 request. The fiscal year 2013 request targets \$2.8 billion in base grants using the State allocation the Congress enacted for fiscal year 2012. The request also includes \$200 million in contingency funds, which will be used to target energy or weather-related emergencies.

*Questions.* It has come to my attention that there are concerns that some high-cost, low-volume radiopharmaceuticals may not be receiving adequate reimbursement under Medicare in the outpatient setting. It is my understanding that today many of these diagnostic drugs are bundled into a payment that may only capture a fraction of their cost. Average Sales Price (ASP) data submitted on a voluntary basis by companies manufacturing radiopharmaceuticals indicates that current Medicare reimbursement for these radiopharmaceuticals is likely below hospital acquisition costs. Has Centers for Medicare & Medicaid Services (CMS) re-evaluated ambulatory payment classifications (APC) payment rates for nuclear medicine procedures or its mean cost data for the radiopharmaceuticals in relation to ASP data? If the new sales data is at odds with CMS calculated costs and the agency believes the discrepancy should be addressed in a fiscally responsible manner, does CMS have the authority to unbundle and pay separately for diagnostic radiopharmaceuticals?

*Answer.* The Medicare outpatient prospective payment system (OPPS), like other Medicare prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated cost of providing a service or bundle of services for a particular patient, but with the exception of outlier cases, the payment is adequate to ensure access to appropriate care. Packaging payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment.

In the calendar year 2008 OPPS rule, CMS finalized a policy to treat diagnostic radiopharmaceuticals differently, for payment purposes, than therapeutic radiopharmaceuticals, as part of a broader packaging policy under the OPPS. For calendar year 2008 through calendar year 2012, we packaged payment for all diagnostic radiopharmaceuticals into the major procedure that it was performed with, most commonly nuclear medicine scan procedures. We finalized this policy because we view diagnostic radiopharmaceuticals as functioning effectively as supplies that

enable the provision of an independent service and are always ancillary and supportive to an independent service, rather than serving as a therapeutic modality.

While we package the cost of diagnostic radiopharmaceuticals into payment for the nuclear medicine scan as a single diagnostic modality, the OPSS makes separate payment for both therapeutic radiopharmaceuticals and brachytherapy sources as a distinct therapeutic modality.

For the calendar year 2012 OPSS, we continue to package payment for nonpass-through diagnostic radiopharmaceuticals into payment for their associated nuclear medicine procedures. We have established claims processing edits (called procedure-to-radiolabeled product edits) requiring the presence of a radiopharmaceutical or other radiolabeled product HCPCS code, including brachytherapy sources and therapeutic radiopharmaceuticals, when a separately payable nuclear medicine procedure is present on a claim. This enables hospital's reported charges for diagnostic radiopharmaceuticals to be incorporated into the annual APC payment rate setting calculations, and provides assurance that the claims information we use in rate setting are accurate and reflects the associated cost of the single diagnostic modality. We evaluate these claims processing edits every quarter to ensure that they are up to date.

We incorporate the line-item estimated cost for diagnostic radiopharmaceuticals in our claims data as a reasonable and accurate approximation of average acquisition and handling costs for diagnostic radiopharmaceuticals. We therefore use these estimated costs to establish payment rates for the separately payable product with which the diagnostic radiopharmaceutical is packaged. We evaluate and establish these APC payment rates on a yearly basis, to reflect changes in service costs as well as practice patterns.

We also note that, in the event that the diagnostic radiopharmaceuticals packaged into the primary procedure's payment are sufficiently costly, the separately payable major procedure would be eligible for an OPSS outlier payment, mitigating any impact from extreme costs associated with providing the major procedure.

While the statute allows us the authority to pay separately for these procedures, we believe that the APC payments associated with the primary procedures reflect the costs commonly associated with providing the procedures as well as support the right incentives in the OPSS system for efficiency. Unbundling these procedures would give providers no reason to exercise financial prudence when providing the primary procedure, along with any associated packaged items. Similarly, removing the incentive through packaging, of making cost-efficient decisions, could have an adverse effect on the beneficiary, since they would pay a 20-percent coinsurance for those items.

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#### QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

##### OBESITY FUNDING

*Question.* More than one-third of U.S. adults are obese. The Deep South has the highest obesity rate in the country, with 6 out of 7 States having an obese population higher than 30 percent. The two most obese States in the Nation, Alabama and Mississippi, both have obesity rates more than 32 percent, yet do not receive any obesity prevention funding from the Centers of Disease Control (CDC). Why do public health dollars not track with burden?

*Answer.* In 2008, CDC released a funding opportunity announcement for the State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases. The purpose of this program is to improve healthful eating and physical activity to prevent and control obesity and other chronic diseases by building and sustaining statewide capacity and to implement population-based strategies and interventions. The program currently funds 25 States to address the problems of obesity and other chronic diseases through statewide efforts coordinated with multiple partners.

State-based nutrition and physical activity (obesity) grants were awarded using a competitive process. Applications were reviewed for responsiveness to the eligibility criteria in the Funding Opportunity Announcement (FOA) and underwent an objective review. Applications were scored against the criteria identified and not against one another. For each application, objective review comments were presented to a panel and a vote took place by the panel to determine if the application was approved, disapproved, or deferred. Approved applications were then rank ordered by score and funding decisions made based on the availability of funding, with preference given for States that had higher obesity prevalence rates, provided there

was adequate justification to fund out of rank order. Neither Alabama nor Mississippi met the criteria for funding out of rank order.

CDC is continuing work to improve the effectiveness of obesity related grant programs (nutrition, physical activity and obesity, diabetes, heart disease and stroke, cancer and arthritis) by strengthening coordination and collaboration across individual categorical programs; better defining the range of targeted science-based interventions and activities that will accelerate health improvements; and working with State grantees to identify efficiencies and improve the effectiveness of program investments.

Regardless of whether a State receives funding or not, CDC provides technical assistance to all States.

CDC continues to develop and disseminate tools and resources for funded and nonfunded entities to inform the development and implementation of State and local strategies to improve healthful eating and physical activity to prevent and control obesity.

CENTERS FOR MEDICARE & MEDICAID SERVICES DEMOS/CENTER FOR MEDICARE AND  
MEDICAID INNOVATION

*Question.* The Center for Medicare and Medicaid Innovation (CMMI) was established in the Affordable Care Act to “test payment and services delivery models to reduce program expenditures” under Medicare and Medicaid. The law appropriated \$10 billion to fund these new models. At a time when the Nation’s healthcare entitlement programs are facing severe financial strain, I am concerned that funds are being expended by CMMI with little to no value provided and further threaten the entitlement programs’ solvency. Have you received estimates from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary that demonstrate that any program developed by CMMI is generating lower Medicare spending?

*Answer.* During the development of initiatives under the authority of section 1115A(f) of the Social Security Act (ACA section 3021), the Innovation Center works closely with the CMS Office of the Actuary to develop potential models, ensure the potential model will accurately test the changes in the delivery of care, and project the expected financial implications of the model. The Innovation Center prepares estimates of the financial impact of the proposed initiatives, as well as an analysis of their potential impact on the quality of health and healthcare among beneficiaries, an examination of current costs of the targeted healthcare service, an analysis of the potential savings, and a review of the prior research that supports testing the initiative. The Office of the Actuary has participated in reviewing these savings estimates and in some cases produced estimates.

*Question.* While the Innovation Center typically works closely with the Office of the Actuary during the development of models, the statutorily mandated certification of savings by the Chief Actuary does not occur in the design phase, but rather in the testing phase to determine whether modification or termination of the testing of a model is needed and after the conclusion of the demonstration to inform whether there should be expansion or wide-scale adoption of the initiative. To date, none of the Innovation Center models have been in the testing phase long enough to generate sufficient data for the Chief Actuary to make such determinations. We believe that the Innovation Center’s evidence-based approach to innovation will result in reducing healthcare costs while improving quality.

Secretary Sebelius, can you provide specific measures that are being used to evaluate the impact of the CMMI initiatives on reducing Medicare spending or improving the quality of care?

*Answer.* An evaluation of the model’s performance is planned for each model tested by the Innovation Center. The evaluation is intended to determine the model’s impact on spending, quality of care delivered, and patient health outcomes and experiences. The Innovation Center will align its relevant performance measures to those from the Department of Health and Human Services National Strategy for Quality Improvement in Health Care, as well as measures used for other CMS programs, such as those used for the Physician Quality Reporting System and the Medicare Shared Savings Program.

All participating providers will be required to work with an independent evaluator to track and provide agreed-upon data as needed for the evaluation. As applicable, these data will be merged with administrative claims data collected by CMS to allow assessment of performance on topics such as clinical quality performance, patient functional status, and financial outcomes. The Innovation Center anticipates using multiple cycles of data collection due to the changing nature of the approaches used by participants in response to rapid-cycle feedback. Particular care will be taken to identify the effect of each reform in the context of other interventions.

For example, when evaluating participants in the Comprehensive Primary Care initiative, the Innovation Center will review several types of quality and patient experience measures. These measures will include the following domains:

- patient and caregiver experience;
- care coordination and transitions;
- preventive health;
- practice transformation; and
- at-risk populations.

*Question.* The Congressional Budget Office (CBO) issued a report in January on the “Lessons from Medicare’s Demonstration Projects.” The report found that most programs have not reduced Medicare spending. In nearly every program, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program. In light of this track record, why should we continue to invest billions of dollars into CMMI?

*Answer.* We know that reforming our healthcare payment and delivery system won’t be easy. That doesn’t make it any less necessary.

Before the Innovation Center develops a new model for testing, it conducts a thorough review of similar programs’ past performance. This allows us to build on models that have been successful, while avoiding those that have not. When models are in their testing phase, the Innovation Center conducts continuous and rigorous evaluation, to determine the impact that models are having, both on health expenditures and on quality of care. Models that are working will be eligible for expansion, while those that are not will be either modified or terminated.

We note that CBO’s report also included lessons for the design of Medicare demonstrations that may increase a demonstration’s odds of success. These include the timely collection of clinical data, a focus on care transitions, the use of team-based care, and targeted low-cost interventions. Much of the Innovation Center’s work embodies these areas of focus, and all Innovation Center demonstrations emphasize rapid evaluation and ongoing data collection.

The Innovation Center is tasked with testing new and innovative payment and delivery models. By definition, such models are unproven. While we select models with high potential to improve quality and reduce costs, it is likely that some will prove successful, and others may not. The only way we can find out is by testing and rigorously evaluating them. However, the one thing we cannot afford is to choose not try new approaches, simply because they might fail. This would ensure that we are left with an outdated and unaffordable healthcare system, which misses opportunities to provide patients with high-quality, affordable care.

#### CENTERS FOR MEDICARE & MEDICAID SERVICES EXCHANGE

*Question.* Secretary Sebelius, some States, for example Alabama, have decided against setting up a new State-based exchange. If a State elects not to establish an exchange, under law, CMS must establish a federally facilitated exchange in that State. Is the Federal exchange on track to begin January 1, 2014, as advertised?

*Answer.* Yes. CMS is currently working to implement a federally facilitated Exchange, including important business functions such as eligibility and enrollment, plan management, and consumer outreach. In addition, contracts have been awarded to build the information technology systems essential to exchange operations.

*Question.* The budget proposes a significant 50-percent reduction in State High-Risk Pool funding with the expectation that States will transition to operational exchanges. In light of the fact that some States are not setting up an exchange, can you elaborate on how the transition from high-risk pools to exchanges is going?

*Answer.* The fiscal year 2013 President’s budget request provides sufficient funding to States as they begin scaling down activities in their existing State High-Risk Pools and enrollees are transitioned to Affordable Insurance Exchanges in 2014.

HHS is working diligently with our Federal and State partners to ensure exchanges are available to all Americans by January 2014. Much of the needed infrastructure work will occur in 2012, and beginning in 2013, major business processes will become operational in anticipation of open enrollment in the exchanges in October 2013. We continue to work with States to ensure that they are ready to begin exchange operations in 2014 to maintain coverage for State High-Risk Pool enrollees.

#### CHILDREN’S HOSPITAL GRADUATE MEDICAL EDUCATION

*Question.* The Children’s Hospitals Graduate Medical Education (CHGME) program supports the training of residents and fellows and increases the supply of primary care and pediatric medical and surgical subspecialties. Nationwide, free-standing children’s hospitals have trained 49 percent of all pediatric residents and

51 percent of all pediatric specialists. The President's budget proposes to decrease funding for training pediatric residency positions \$177 million less than fiscal year 2012. Meanwhile, the budget proposes to begin a new Pediatric Specialty Loan Repayment (PSLR) program to repay medical school loans. It seems illogical that we would allocate funding to repay loans of physicians but reduce the funding to train physicians. What is the rationale behind this decision?

Answer. We recognize the vital role that children's hospitals and pediatric providers play in providing quality healthcare to our Nation's children. The fiscal year 2013 CHGME funding level continues to support direct costs for training pediatric residents at independent children's hospitals. This payment provides support for resident salaries, expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, cost associated with providing the GME training program, and allocated institutional overhead costs.

The fiscal year 2013 budget retains the incentive to maintain total resident levels. The administration recognizes that research has indicated that there is a significant shortage of pediatric subspecialists, resulting in children with serious illnesses being forced to travel long distances—or wait long periods—to see a pediatric specialist. In response to these shortages, the fiscal year 2013 President's budget includes \$5 million to implement the PSLR program that was authorized in the Affordable Care Act (ACA). Under this program, loan repayment agreements will be authorized for pediatric specialists who agree to work in underserved areas.

While both the CHGME payment and the PSLR programs support the pediatric medical workforce, the focus of each is different. The CHGME Payment Program serves the purpose of providing residency training in Children's Hospitals through the payments made to Children's Hospitals, while the PSLR program is designed to assist pediatric specialists more directly and increase the number of pediatric specialists in underserved areas.

#### LOBBYING RESTRICTIONS

*Question.* Secretary Sebelius, I am concerned about the Department's implementation of a longstanding Federal prohibition on lobbying with Federal tax dollars. Yesterday you testified before the House Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee that you believe it is both legal and appropriate for grantees to lobby local governments.

I believe the interpretation is clear—Federal funds cannot be used to change policies at the Federal, State, or local level. However, I have several examples of Federal funds being used to secure bill sponsors, draft legislation, and lobby for tax increases. How will you clarify this misinterpretation by agencies within the Department, and what steps will you take to ensure a full investigation occurs regarding any Federal tax dollars that were misused for lobbying activities?

Answer. HHS is committed to ensuring the proper use of appropriated funds, and to ensuring awardees' compliance with all applicable regulations and statutes related to lobbying activities, including Office of Management and Budget (OMB) Circular A-122: Cost Principles for Non-Profit Organizations; OMB Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments; and our own policy regarding lobbying activities.

HHS awardees are informed about the Federal laws relating to use of Federal funds, including applicable anti-lobbying provisions. Not only are the restrictions noted within HHS funding opportunity announcements, the lobbying prohibition is also included within the terms and conditions to which each awardee agrees prior to receiving Federal funds. In addition, HHS staff monitor the use of Federal funds by awardees using tools such as on-site review and risk mitigation plans.

Applicable lobbying restrictions do not prohibit awardees from all interactions with policymakers or the public. Federal law allows many activities that are not considered lobbying and that community awardees may decide to pursue. For example, awardees may use funds to disseminate information about public health programs and science-based solutions and to implement specific programs, such as evidence-based educational materials and media on the health effects of increasing physical activity or decreasing exposure to secondhand smoke.

At HHS, we are committed to fulfilling the mandates from the Congress to empower communities to pursue high-quality, science-based programs that make a real difference in the health of Americans. We take our responsibility as stewards of taxpayer dollars very seriously, and we are committed to enabling awardees' success and to ensuring that Federal funds are used efficiently and appropriately.

## HEALTHCARE PREMIUMS

*Question.* Secretary Sebelius, we have repeatedly heard from this administration and the President that health insurance premiums will be lowered by the end of the President's first term. In February 2008 President Obama stated: "We're going to work with you to lower your premiums by \$2,500 per family per year. And we will not wait 20 years from now to do it or 10 years from now to do it. We will do it by the end of my first term as President." However, yesterday you testified before the House Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee that health insurance premiums could not be lowered by \$2,500 until the exchanges come online in 2014. Madam Secretary, is it possible that premiums will be lowered by the end of this year or is this an abandoned campaign promise?

*Answer.* ACA contains market reforms that will reduce premium costs for the same level of benefits. Most of the market reforms that will impact premium costs, such as exchanges, will not be in place until 2014. Until the exchanges are implemented, consumers have limited ability to compare across options to get the best value for their premium dollars, and health insurance issuers have less incentive to compete. We may not realize premium decreases until such time as exchanges and other market reforms are fully operational.

## DUPLICATION AND OVERLAP

*Question.* The Government Accountability Office (GAO) released a report in February that stated, "HHS is collaborating with Labor to conduct an evaluation to better understand policies, practices, and service delivery strategies that lead to better alignment of the Workforce Investment Act (WIA) and Temporary Assistance for Needy Families (TANF)." Can you provide further information on this collaboration, including examples of State and local practices that may be models for other areas to follow and how WIA-TANF duplication can be reduced?

*Answer.* The Administration for Children and Families (ACF) remains committed to bringing about better alignment of Federal investments in job training, improved models for delivering quality services across programs at lower costs, and providing relevant information to workforce and social service communities. In order to address GAO's recommendation for developing and disseminating information on State and local efforts and initiatives to increase administrative efficiencies, both Departments are exploring a variety of efforts aimed at addressing the challenges, strategies, incentives, and results for States and localities to undertake such initiatives, including developing joint administrative guidance, technical assistance and outreach, leveraging research resources and other collaborative efforts. Some examples of these efforts include:

- A partnership between ACF and the Employment and Training Administration (ETA) encouraged workforce and human service agencies to co-enroll youth in WIA and TANF programs and leverage TANF funds to cover subsidized wages for youth, thus promoting effective and efficient leveraging of Federal resources to expand summer employment opportunities for 2010.
- For program year 2012, ETA has consulted with multiple stakeholders, including ACF and other agencies, to redesign ETA's plan guidance related to WIA submissions.
- The Career Pathways Technical Assistance Initiative grants, led by an inter-agency work group consisting of staff from ACF, ETA and the Department of Education's Office for Vocational and Adult Education, leverages the latest research and best practices to help grantees in the workforce and human services agencies form partnerships to improve employment and training outcomes for low-skilled individuals.
- Ongoing monthly meetings of the Departments of Labor, Health and Human Services Research Working Group allows for sharing of current research, helps to identify gaps and to explore additional areas for potential collaboration.
- To gain a better understanding of the TANF-WIA integration that a number of States have implemented, ACF and ETA jointly plan to develop an approach to identify existing promising WIA and TANF linkages.

*Question.* In February, the Government Accountability Office (GAO) released a report on duplication, fragmentation, and cost-saving opportunities in the Federal Government. The report noted that there are several areas where the Department of Health and Human Services (HHS) may be duplicating work with other Federal agencies. In particular, GAO found that the National Institutes of Health (NIH), Department of Defense (DOD), and the Veterans Administration (VA) each lack comprehensive information on health research funded by other agencies, which means that duplication may sometimes go undetected. Secretary Sebelius, what are you

doing to ensure that HHS is improving the ability of agency officials to identify possibly duplication?

Answer. HHS continues to work with other Federal agencies and the Congress to address areas of duplication identified by GAO. To date, HHS has addressed or partially addressed a number of the actions recommended by GAO. For example, HHS has been working with the VA and HUD to better coordinate the collection, analysis, and reporting of homelessness data. HHS is also collaborating with the Department of Labor (DOL) to promote administrative efficiencies within employment and training programs. In addition, the fiscal year 2013 budget proposes to transfer the Senior Community Service Employment Program from DOL to HHS to further reduce duplication of efforts.

NIH efforts to address duplication include resources to examine details of existing funding when evaluating overlap such as access to an Electronic Research Administration (eRA) module called QVR (for Query/View/Report). QVR provides extensive data about funded grant and unfunded grant applications. NIH makes the QVR resource available to other Federal agencies, contingent upon acceptance of the formal data access agreement. In fact, the VA currently uses the NIH eRA system for some of their applications. DOD staff may request access to QVR and may also obtain training in the use of QVR.

NIH is also an acceptable grant processing site under the Grants Management Line of Business (GMLoB) Initiative and is available to DOD. HHS will continue to work with other Federal agencies and the Congress to address areas of duplication identified by GAO.

*Question.* GAO found the Federal investment in early learning and child care is fragmented, with overlapping goals and activities. For example, five programs within HHS and the Department of Education (ED) provide school readiness services to low-income children. These similar programs in different agencies create added administrative costs and confusion. What steps are you taking to identify and minimize unwarranted overlap in early learning and child care programs?

Answer. Cross-program coordination to ensure that children have access to high-quality early learning and child care programs has been a priority and key focus for the administration. Over the last 3 years, ACF has developed and implemented an integrated early childhood unit under the leadership of the Office of the Deputy Assistant Secretary for Early Childhood Development, which has become the focal point within HHS for early childhood activities at the Federal level. Within this structure, the administration has taken several steps to improve coordination between the Office of Child Care (OCC) and Office of Head Start (OHS), such as establishing the National Center on Child Care Professional Systems and Workforce Initiatives funded by both OCC and OHS, implementing the Early Head Start for Family Child Care Demonstration Project jointly coordinated by OCC and OHS, and issuing joint guidance on aligning eligibility policies across Head Start and child care programs.

The administration has many interagency and interdepartmental efforts to coordinate federally funded early care and education programs:

*State Advisory Councils on Early Childhood Education and Care.* The Improving Head Start for School Readiness Act of 2007 required that the Governor of each participating State designate or establish a council to serve as the State Advisory Council on Early Childhood Education and Care for children from birth to school entry. The State Advisory Councils will lead the development or enhancement of a high-quality, comprehensive system of early childhood education and care that ensures statewide coordination and collaboration, while addressing how best to prevent duplicative services among the wide range of early childhood programs and services in the State, including child care, Head Start, Individuals with Disabilities Education Act preschool and infants and families programs, and pre-kindergarten programs and services. ACF awarded \$100 million of American Recovery and Reinvestment Act (ARRA) funding for State Advisory Councils to 45 States, the District of Columbia, Puerto Rico, Virgin Islands, and American Samoa.

*Early Learning Interagency Policy Board.* The Secretaries of ED and HHS established the Early Learning Interagency Policy Board to improve the quality of early learning programs and outcomes for young children; increase the coordination of research, technical assistance and data systems; and advance the effectiveness of the early learning workforce among the major federally funded early learning programs across ED and HHS.

*ACF/Child and Adult Care Food Program (CACFP) Workgroup.* Convened by OMB, the ACF/CACFP Workgroup brings together staff from the Food and Nutrition Services, OCC, and OHS to discuss possible collaboration around the CACFP. The workgroup has identified the following areas of collaboration:

- sharing the National Disqualified List;
- publishing joint information memorandums on collaboration at the State and local level; and
- improving tribal participation in CACFP.

In addition, the administration's Race to the Top—Early Learning Challenge grants, administered jointly by ED and HHS—are designed to foster innovation and integration within early education programs within a State. In 2011, nine States were awarded Early Learning Challenge Grants and in April 2012, the two departments announced that five additional States were eligible for such grants. While each State has its own areas of focus, all States are working to improve early education in all settings so that more high need children are receiving high-quality early education services. States are focusing on workforce training, early learning standards, developing data systems to track children's progress, and engaging families to promote academic success for children. And, all States are working on these areas across all types of early learning programs, including public pre-K, Head Start, privately funded preschool, and child care (such as child care centers and family day care homes).

Finally, several of the Child Care Development Fund (CCDF) principles for reauthorization included in the President's budget request would streamline Federal, State, and local early care and education programs. For example, the budget proposal supports promoting continuity of care for children and quality improvement for child care providers.

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#### QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

##### ELIMINATION OF PREVENTIVE HEALTH BLOCK GRANT

*Question.* I am concerned about the elimination of the Preventive Health and Health Services Block Grant. The block grant gives States the autonomy and flexibility to solve State problems and address community level needs, while still being held accountable for demonstrating the local, State, and national impact of this investment. Eliminating this source of flexible funding would jeopardize important public health programs already strained by tightening budgets. I am concerned that states without capacity will be disproportionately affected by the elimination of this formula grant. Additionally, I am concerned that your budget proposes to fill the need for the block grant with competitive programs funded by the Affordable Care Act. Secretary Sebelius, how are you proposing States address community health needs to keep their citizens healthy and safe without the Prevent Block Grant?

*Answer.* Through Centers for Disease Control and Prevention's (CDC) existing and expanding activities, there is substantial funding to State health departments to address community health needs. The activities currently supported by the Preventive Health and Health Services Block Grant may be more effectively and efficiently implemented through the new Coordinated Chronic Disease Prevention and Health Promotion Grant. The budget includes \$379 million, an increase of \$129 million more than fiscal year 2012, for the Coordinated Chronic Disease Prevention and Health Promotion Program. This program consolidates disease-specific chronic disease funding into a comprehensive program to address the leading chronic disease causes of death and disability, including heart disease and stroke, obesity, diabetes, arthritis and the primary preventable causes of cancer, tobacco use, poor nutrition, and physical inactivity. Because many inter-related chronic diseases and conditions share common risk factors, this program will improve health outcomes by coordinating interventions that benefit multiple chronic diseases. As a result, the program will gain efficiencies in cross-cutting areas such as epidemiology and surveillance, supporting healthful behaviors and chronic disease self-management, and improving effective delivery of clinical and other preventive services. At the end of the fiscal year, CDC will report on the funding spent on prevention and control of specific diseases. At the end of the 5-year program, CDC will report on improvements in outcomes specific to each disease as well as cross-cutting outcomes.

##### TEEN PREGNANCY PREVENTION

*Question.* Teen and unplanned pregnancy costs taxpayers billions of dollars every year, and contributes to a cycle of poor outcomes that affect the long-term strength of our workforce. The Mississippi Economic Council released a report in January that the State's high teen childbearing rate was a hindrance to having an educated and competitive workforce. They recommend reducing teen pregnancy as a part of improving economic development. Do you have the resources you need to spearhead a successful effort to reduce teen and unplanned pregnancy?

Answer. Teen mothers and their children are more likely to face a range of challenges and adverse conditions when it comes to the health and economic security of themselves and their children. That is why my strategic plan for the Department identifies reducing rates of teen pregnancy as a priority.<sup>1</sup> HHS is making investments in strategies that give children and youth a positive start in life and is committed to supporting both evidence-based programs and innovative approaches for children and youth in order to positively impact a range of important social outcomes, such as child maltreatment, school readiness, teen pregnancy prevention, sexually transmitted infections, and delinquency.

The budget proposes to use unobligated Abstinence Education funds from the Title V State Abstinence Education Grant Program for a new initiative to address pregnancy prevention among youth in foster care, who have an estimated 50 percent teen pregnancy rate. The new initiative will not reduce the amount available to States for Abstinence Education. Each year, some States choose not to draw down their allotment of Title V Abstinence Education funds. Instead of lapsing, these funds will be redirected to help youth in the foster care system avoid pregnancy.

Beginning in fiscal year 2010, under the Teen Pregnancy Prevention Program, the Office of Adolescent Health has provided \$75 million in grant funds to States, non-profit organizations, school districts, universities, and other organizations to replicate models that have been rigorously evaluated and shown to be effective at reducing teen pregnancies, sexually transmitted infections, or other associated sexual risk behaviors. An additional \$25 million in grant funding also supports research and demonstration projects to develop and test additional models and innovative strategies to prevent teen pregnancy, so that evidence base continues to expand and refine. This program supports 102 grant projects in 36 States and the District of Columbia.

Through the Personal Responsibility Education Program (PREP), authorized by the Affordable Care Act, the Administration for Children and Families provides \$55 million in formula grants to States to support evidence-based program models or to substantially incorporate elements of effective prevention programs while including three of six adult preparation subjects mandated by the Congress. To date, 45 States as well as DC, Puerto Rico, the Virgin Islands, and the Federated States of Micronesia had accepted PREP funds. In addition, 16 PREP grants were awarded to tribes and tribal organizations in the summer of 2011. The PREP program also includes \$10 million in competitive PREP Innovative Strategies cooperative agreement research and demonstration grants to develop and test additional models and innovative strategies. The PREP Innovative Strategies program awarded 13 grants through the joint funding announcement with OAH. Both programs target groups with high teen pregnancy rates. In addition, the Affordable Care Act gives States the option of expanding eligibility for Medicaid family planning services without having to go through the Federal waiver process. Despite these substantial investments much work remains in reaching adolescents given there are an estimated 47 million persons ages 10–19 of age in the United States. Increased training for the multiple professionals who touch the lives of young people, media campaigns, and well-coordinated care services at the community level can all help ensure healthy, productive and hopeful young persons.

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#### QUESTIONS SUBMITTED BY SENATOR LAMAR ALEXANDER

##### PATIENT PROTECTION AND AFFORDABLE CARE ACT REGULATIONS

*Question.* Please provide a schedule of when you expect upcoming healthcare regulations will be published. Senior administration staff previously indicated that many of the interim final rules will be reissued as final rules. Is this true? If so, please include the dates you expect the interim final rules will be reissued as final rules as part of the schedule mentioned above.

In December, the administration published a “bulletin” on essential health benefits—the mandates that all new health plans sold to individuals and small businesses will be required to provide in 2014 and beyond. The “bulletin” fails to answer basic questions from States and employers.

—When will you provide the details regarding benefit mandates and the other new insurance rules, so that we can know how much premiums will be raised and how much Federal costs will increase?

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<sup>1</sup> [http://www.hhs.gov/secretary/about/priorities/youth\\_futures.html](http://www.hhs.gov/secretary/about/priorities/youth_futures.html)

—The “bulletin” tells States they must choose among four options before September 2012. Will a rule be finalized before the September 2012 deadline the “bulletin” places on States?

—How can States be expected to implement a “bulletin” which has no force of law?

Answer. Centers for Medicare & Medicaid Services (CMS) issued a bulletin on December 16, 2011 and has gathered input. CMS will take public input into consideration and then issue a Notice of Proposed Rulemaking. The bulletin announced CMS’s intended regulatory approach for defining the essential health benefits, based on a State-selected benchmark plan. States will need to make their selection and submit their essential health benefits benchmark to U.S. Department of Health and Human Services (HHS) in the third quarter of 2012 for coverage year 2014.

PATIENT PROTECTION AND AFFORDABLE CARE ACT ACCOUNTING

*Question.* The new healthcare law appropriates “such sums as may be necessary” to implement the State-based health insurance exchanges. Your budget estimates spending \$1.087 billion in mandatory money for fiscal year 2013.

How much will the Department have spent on health insurance exchanges since the time the healthcare bill was signed into law until 2014 when the exchanges are supposed to be fully operational?

Answer. Our current baseline for Exchange Planning and Establishment Grants estimates that we will obligate approximately \$2.5 billion from when the law was enacted until fiscal year 2014 and that we will outlay \$2 billion during that timeframe.

*Question.* In addition to this mandatory money for State-based health insurance exchanges, the President’s 2013 budget requests an additional \$864 million for the Federal exchange and other exchange activities. How will this money specifically be spent and how will the Federal exchange differ in functionality from the web portal HHS has already implemented?

Answer. As with the State-based exchanges, fiscal year 2013 is the year many operations of the federally facilitated exchange begin, as CMS will need to be prepared for open enrollment on October 1, 2013, the first day of fiscal year 2014. The majority of the \$864 million request for CMS’s exchange work is related to operations and management of the federally facilitated exchange with some funding to support the Secretary’s duties on behalf of all exchanges. Specifically, \$574.5 million of the total will be used for exchange operations and management including eligibility and enrollment functions, certifying health insurance plans as qualified to be sold through the exchange, as well as oversight of plans and State-based exchanges. The additional \$289.5 million will be used for consumer education and outreach activities, such as a call center, to help consumers understand their new options under the Affordable Care Act (ACA) and to fund navigators and in-person enrollment assistance to facilitate the enrollment process.

Healthcare.gov is a useful tool for providing information on potential sources of insurance available to individuals today, and HHS can leverage its capabilities for presenting information to assist consumers in comparing across plans in exchanges. The federally facilitated exchange will go beyond what is available through Healthcare.gov by certifying that the plans offered meet certain standards of quality and benefits. The federally facilitated exchange will also perform eligibility determinations, enroll individuals into plans, and provide for in-person or call center support to answer questions about available coverage.

The healthcare law included a \$1 billion implementation fund. In order for the Congress to better evaluate the administration’s request for additional funds for implementation activities, please provide an accounting of how the monies provided pursuant to the new healthcare law have been expended. As part of your answer, please include a comprehensive breakdown of spending by department and subsidiary administrative units, as well as by function.

Answer. The following table displays the spending from the Health Insurance Reform Implementation Fund as of February 29, 2012, by agency:

Organization	Obligations	Outlays
Internal Revenue Service .....	\$213,264,945	\$154,181,697
Office of Personnel Management .....	2,938,850	1,442,102
Department of Labor .....	3,055,102	2,958,880
Department of Health and Human Services .....	251,742,492	134,917,483
Total, Health Reform Implementation Fund .....	471,001,389	293,500,162

HHS uses these funds to implement Medicare and Medicaid changes required in the ACA, including closing the Part D coverage gap and developing new value-based purchasing models for Medicare providers. HHS has also used these funds to plan and prepare for the establishment of State-based and federally facilitated exchanges as required in the ACA.

The Office of Personnel Management (OPM) uses funding to plan for implementing and overseeing the establishment of at least two Multi-State Plan Options to be offered on each State health insurance exchange beginning in 2014, and allowing tribes and tribal organizations to purchase Federal health and life insurance for their employees.

The Department of the Treasury uses funding to implement multiple tax changes from the ACA, including the Small Business Tax Credit, expanded adoption credit, excise tax on indoor tanning services, charitable hospital requirements, plan for exchanges, and a number of other revenue provisions.

The Department of Labor uses funds to conduct compliance assistance; modify or develop IT systems that support data collection, reporting, policy and research; and develop infrastructure for the newly required Multiple Entity Welfare Arrangements reporting and registration within ACA.

Of the \$251,742,492 obligated by HHS to date, approximately 13 percent has paid for personnel, 84 percent has supported contractual services, and 3 percent has been obligated for rent, supplies, or other miscellaneous services.

*Question.* The HHS budget calls for 76,341 employees in fiscal year 2013. This is an increase of nearly 1,400 employees over the fiscal year 2012 level. How many of these employees will be hired to implement the new healthcare law?

*Answer.* At the Centers for Medicare & Medicaid Service (CMS), the President's budget requests an increase of 136 full-time equivalents more than the fiscal year 2012 appropriated level to enable CMS to address the needs of a growing Medicare population, as well as oversee expanded responsibilities from legislation passed in recent years.

*Question.* How many staff members are currently working at the Center for Consumer Information and Insurance Oversight (CCIIO)? Please provide numbers for both full-time and part-time staff separately.

*Answer.* As of March 10, 2012, CCIIO has approximately 261 employees on-board. 258 employees are considered full-time, and 3 employees are considered part-time. This staff is supported by a combination of discretionary funds and mandatory ACA funding.

*Question.* How many staff do you expect will be working at CCIIO at the end of fiscal year 2012? How many staff do you expect will be working at CCIIO at the end of fiscal year 2013?

*Answer.* By the end of fiscal year 2012, CMS expects to use 450 FTEs on CCIIO-related activities. This staffing level will grow to a projected 710 FTEs by the end of fiscal year 2013 as CMS brings the exchanges online and implements consumer protections and other reforms.

#### CENTERS OF EXCELLENCE IN EARLY CHILDHOOD

*Question.* In the 2007, the Congress authorized the establishment of Centers of Excellence in Early Childhood for the purpose of evaluating the success of Head Start and other early childhood programs funded by the Federal Government. However, minimal funding has been allocated to support these Centers. At the same time, the Federal Government continues to fund more and more programs focused on early education. The President's fiscal year 2013 budget further requests additional funding, through Race to the Top, for an Early Learning Challenge Fund.

Rather than just adding to the duplicative list of funding silos for early education, wouldn't this money be better spent in support of the Head Start Centers of Excellence so that we can figure out what is working and what is not working?

*Answer.* The Departments of Health and Human Services and Education have been working collaboratively reduce and prevent silos and duplication of efforts between our two Departments, to develop the infrastructure and models to maximize the use of Federal dollars at the State, and local levels and to build accountability into all Federal funds. Both the Race to the Top—Early Learning Challenge and the Head Start Centers of Excellence in Early Childhood are examples of our efforts. However, these efforts have very different goals. There are 10 Head Start Centers of Excellence that serve as models for other individual programs. This funding has provided an excellent opportunity to showcase these Head Start programs so that other early childhood programs may benefit from their best practices. In contrast, the Race to the Top—Early Learning Challenge provides grants to States that target broad systems of reform across all early childhood programs, including building

the infrastructure in States to better manage funding and minimize duplication of efforts. The goal of Race to the Top and our other interagency work is to provide greater continuity between schools, child care programs, Head Start programs, and State-funded pre-kindergarten programs.

## CO-OPS

*Question.* The Department of Health and Human Services issued rules governing the grants for the Consumer Oriented and Operated Plan (CO-OP) program on July 20, 2010. On February 21, 2012, the Department released the identities of the first eight grants/loans recipients.<sup>1</sup> One of the grant recipients was the Common Ground Healthcare Cooperative of Wisconsin, which is an organization affiliated with the liberal activist group Industrial Areas Foundation. Common Ground was reportedly formed in August 2011, just 3 months prior to applying for the taxpayer money, and will receive \$56,416,000.

What criteria were used to select CO-OP grant recipients? Specifically what criteria were used to assess their experience in providing health insurance and benefits?

*Answer.* CO-OP loan applications are subject to rigorous review and vetting by CMS' independent contractors, and by a review committee in CMS, which is separate from the CMS group responsible for administering the CO-OP program. CMS and these experts evaluate applicants based on their financial models and business plan, the applicant's ability to meet the regulatory standards and milestones for development, the likely long-term sustainability of the plan, adherence to the health policy goal of consumer operation and orientation, and the likelihood of loan repayment. The awards are also subject to legal review. Each CO-OP must be licensed as a health insurance issuer in each State in which it offers a health insurance plan. In addition, CO-OPs must meet the same requirements that other health insurance issuers must meet in each State. All CO-OPs are selected based on their viability and potential for success, as evidenced in their detailed business plans, financial plans, and actuarial projections.

*Question.* Is it true that the HHS rules regarding CO-OPs projected a 35–40 percent default rate?

*Answer.* The regulatory impact analysis in the CO-OP proposed rule (76 FR 43237) included an estimate of a technical default rate but incorrectly described it as an estimate of a non-repayment rate.

The default rate is not an estimate of insolvencies. The rules did not estimate insolvencies.

Because of Federal accounting rules, the default estimate includes loan recipients that CMS expects will fully repay the loan and at all times will be compliant with their loan agreement and Federal law. For example, the Affordable Care Act, in section 1322, requires the repayment of loans, but repayment terms "must take into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements." The statute envisions occasions, such as when a loan recipient must keep additional State-mandated insurance reserve requirements, when it is in the best interest of the consumer, loan recipient, and the State regulator for Department to change the loan repayment terms. This is one of many examples in which a loan recipient may be considered a default and included in the default rate estimated in the rules but is not in financial distress.

Given the high bar to receiving funds, the detailed monitoring and oversight by CMS, and the concurrent oversight by State insurance regulators, we expect a high percentage of CO-OP loans to be repaid in full.

All CO-OP loans must be repaid with interest and loans will only be made to private, nonprofit entities that demonstrate a high probability of becoming financially viable. In addition, as described in the Funding Opportunity Announcement, CMS has built in a strong monitoring process to ensure that CO-OPs are meeting development milestones according to prescribed timetables. Loan recipients are subject to strict monitoring, audits, and reporting requirements for the length of the loan repayment period plus 10 years. To ensure strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow data, receive site visits by CMS staff, and undergo annual external audits, in order to promote sustainability and capacity to repay loans. This monitoring is concurrent with ongoing financial and operational monitoring by State insurance regulators. In addition, CMS will use all remedies available in law or equity to collect unpaid loans.

<sup>1</sup> <http://www.jsonline.com/business/nonprofit-health-insurer-lands-Federal-loan-rm49ho7-139863553.html>

## EXCHANGE GRANTS

*Question.* Patient Protection and Affordable Care Act (PPACA) section 1311(a) enables the Secretary of HHS to make planning and establishment grants each year to the States. The law specifies that the Secretary shall determine the amount to be made available to States, but it does not specify how the Secretary should make the determination. So far HHS has spent nearly \$1 billion on exchange grants, but it is not clear how these monies are being used.

Please identify all recipients of the planning and establishment grants and explain the criteria you used to determine how much to award to each grantee. As part of your answer, please include the total amounts each grantee received and identify how each grantee has indicated they will spend these funds.

*Answer.* States are required to submit detailed budgets as part of their grant applications. These budgets must outline the costs for each of the exchange core areas on which they will be working under the grant (e.g., IT systems, outreach and education, etc.) including administrative and overhead costs. These budgets are carefully reviewed and negotiated with the State before each award is made to ensure they represent a valid cost estimate to perform activities required under the grant.

*Question.* In general, States used Planning Grant funding to perform such activities as insurance market analysis and stakeholder outreach to provide the information necessary to make initial policy decisions about how an exchange could best serve their residents. Many States are using Level I Establishment grants to begin work on their eligibility systems and other IT systems, to develop consumer assistance functions, and to implement the plan management infrastructure necessary to certify qualified health plans. The State of Rhode Island has a Level II Establishment Grant for work to establish all core functions of a State-based exchange. For a complete list of States that have been awarded Establishment Grants, the specific activities they are performing under those grants, and the amounts that have been awarded, please see: <http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html>.

Please also describe the process for selecting grantees, identifying whether this was a competitive process, and if so, what criteria were used to evaluate grant applications.

*Answer.* The funding provided under section 1311 of the Affordable Care Act is available to fund activities of any State for activities necessary to establish an exchange. All grant applications are subject to objective review by programmatic experts to ensure that requirements outlined in the funding opportunity announcement are satisfied.

## PREVENTION FUND

*Question.* Recently enacted legislation to extend unemployment insurance, payroll tax provisions and delay a scheduled reduction in Medicare payments to physicians was paid for in part by a \$5 billion reduction in the prevention fund. In addition, the President's budget also called for a \$5 billion reduction in this fund. In light of the bipartisan interest in reducing the monies allocated to this fund, we would request that you provide the following information to help us assess the effectiveness of the expenditures authorized under the fund.

Please describe how the programs funded under section 4002 of PPACA are being measured to determine their efficacy. As part of your answer, please indicate whether and how each program is evaluated to determine how it improves health outcomes for identified individuals and reduces healthcare expenditures.

*Answer.* HHS strives to ensure that programs funded by the Prevention and Public Health Fund (PPHF) are making the greatest health impacts. Within the programs, the Department assigns a trained project officer to monitor and advise each grantee. Project officers provide ongoing consultation and oversight to grantees regarding program performance.

Project officers also conduct site visits in order to objectively validate information and actively resolve challenges that a grantee is facing in order to ensure that the goals of the project are achieved.

Programmatic performance measures also have been developed for each PPHF funded program at three levels:

- performance milestones for start-up;
- short-term impact; and
- long-term objectives.

All PPHF funded programs report twice a year regarding the status of established milestones and measures.

HHS leaders regularly review these performance data to ensure that programs are on track and accountable for the outcomes associated with each investment.

## CHRONIC DISEASE COORDINATION

*Question.* Less than 4 cents of every healthcare \$1 is spent on prevention, yet chronic diseases account for 70 percent of deaths and a huge healthcare cost burden. The CDC budget proposes the consolidation of several existing categorical programs into a single coordinated program. Can you explain what efficiencies you hope to gain from this proposal and what assurances you can give to those who are concerned about losing the identity of disease specific funding streams?

*Answer.* The budget includes \$379 million, an increase of \$129 million more than fiscal year 2012, for the Coordinated Chronic Disease Prevention and Health Promotion Program. This program consolidates disease-specific chronic disease funding into a comprehensive program to address the leading chronic disease causes of death and disability, including heart disease and stroke, obesity, diabetes, arthritis and the primary preventable causes of cancer, tobacco use, poor nutrition, and physical inactivity. Because many inter-related chronic diseases and conditions share common risk factors, this program will improve health outcomes by coordinating interventions that benefit multiple chronic diseases. As a result, the program will gain efficiencies in cross-cutting areas such as epidemiology and surveillance, supporting healthful behaviors and chronic disease self-management, and improving effective delivery of clinical and other preventive services. At the end of the fiscal year, CDC will report on the funding spent on prevention and control of specific diseases. CDC will also report annually on improvements in outcomes specific to each disease as well as cross-cutting outcomes.

## ENVIRONMENTAL HEALTH/LEAD

*Question.* While CDC has prevented approximately 100,000 children from being poisoned by lead each year through the Healthy Homes and Lead Poisoning Prevention Program, in fiscal year 2012 funding was not included for the program. The Committee noted that \$350 million will be spent by HHS to conduct home visiting programs in fiscal year 2012 through the Maternal, Infant, and Early Childhood Home Visiting Program; this funding appropriated by the Patient Protection and Affordable Care Act, is \$100 million more than the fiscal year 2011 level. The subcommittee further stated that it intends the Health Resources and Services Administration and CDC to work together to ensure that activities previously funded through Healthy Homes will be fully incorporated into the Home Visiting Program. How has the Department worked to support this legislative intent?

In fiscal year 2013 again the Healthy Homes and Lead Poisoning Prevention Program was again consolidated and slated for potential elimination. How is the administration going to ensure that the Nation's most vulnerable children are tested for lead poisoning and ensure that if those children test positive that treatment and environmental remediation services are provided?

*Answer.* CDC and HRSA are working to identify possible solutions for incorporating childhood lead poisoning prevention activities into routine services of HRSA's early childhood Home Visiting Program.

The fiscal year 2013 President's budget proposes a new program—Healthy Home and Community Environments—that will incorporate CDC's National Asthma Control Program (NACP) and the Healthy Homes/Lead Poisoning Prevention Program (HHLPPP). The fiscal year 2013 request for the Healthy Home and Community Environments program is \$27.3 million.

The Healthy Home and Community Environments program is a new, multi-faceted approach to address healthy homes and community environments through surveillance, partnerships, and implementation of science-based interventions to address the health impact of environmental exposures in the home and to reduce the burden of disease through comprehensive asthma control. This integrated approach aims to control asthma and mitigate health hazards in homes and communities such as air pollution, lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, unsafe drinking water, and the absence of smoke and carbon monoxide detectors.

*Question.* Given the drastic cuts to CDC's Lead Poisoning Prevention Program that could essentially end all State cooperative agreements, what are your proposed strategies moving forward to ensure that the essential services (emergency response to children with lead poisoning, home inspections that include environmental health components, surveillance, etc.) provided by State and local health departments to vulnerable children are not lost?

*Answer.* With fiscal year 2012 funding, CDC's Healthy Homes and Lead Poisoning Prevention Program will continue to provide lead expertise and analysis at the national level and remain a valuable resource to State and local agencies by providing the following:

*Surveillance Support.*—Provide software and technical assistance to support the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS), which gathers information related to lead and other health hazards in homes.

*Epidemiological Support.*—Maintain staff to provide expertise and epidemiological support in response to a lead poisoning outbreak.

*Subject-Matter Expert Support.*—Maintain the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP). The ACCLPP advises and guides the Secretary and Assistant Secretary of HHS and the Director of CDC regarding new scientific knowledge and technical developments and their practical implications for childhood lead poisoning prevention efforts.

## SECTION 317

*Question.* CDC takes one of the largest hits in the budget request, and especially concerning is the proposed reduction in the section 317 immunization program. A report from CDC estimates that this program is underfunded by hundreds of millions of dollars. Vaccination programs have been proven to be some of the most cost-effective approaches to preventing disease and reducing healthcare costs, and the children's vaccine programs are estimated to be a 10:1 savings as one example. The section 317 program provides the infrastructure for the Vaccines for Children program, which has been a huge success.

What is the rationale for cutting this program by \$58 million or close to 10 percent when we are still 1 to 2 years away from expanded coverage? Will this reduction cut purchase grants or operational support for health departments?

*Answer.* The fiscal year 2013 budget includes funds for vaccine purchase to continue outreach to the hardest-to-serve populations, and critical immunization operations and infrastructure that supports national, State, and local efforts to implement an evidence-based, comprehensive immunization program. The request also specifically directs \$25 million toward continuation of the billables project, which allows public health departments to vaccinate and bill for fully insured individuals in order to maintain section 317 vaccines for the most financially vulnerable and respond to time-urgent vaccine demands, such as outbreak response. The fiscal year 2013 budget will sustain the national immunization program vaccine purchase and immunization infrastructure. The budget does not continue funding for one-time enhancements planned for fiscal year 2012 to modernize the immunization infrastructure through funding to the grantees for improving immunization health IT systems and vaccine coverage among school-age children and adults; expansion of the evidence base for immunization programs and policy; and enhancements to national provider education and public awareness activities to support vaccination across the lifespan.

*Question.* How do you see the role of the section 317 program evolving along with implementation of the Affordable Care Act?

*Answer.* The Affordable Care Act requires new health plans to cover routinely-recommended vaccines without cost-sharing when provided by an in-network provider. As these health insurance reforms expand prevention services to more Americans, the size of the population currently served by section 317 vaccine is expected to decrease in size, specifically underinsured children. The Section 317 Immunization Program will continue to have a critical role in providing vaccines to meet the needs of uninsured adults and responding to urgent vaccine needs such as outbreak response, and ensuring the necessary infrastructure is in place to support the Nation's immunization system for both routine vaccination as well as managing vaccine shortages and other emergency response. This critical infrastructure serves both the public (e.g., Vaccines For Children Program and Section 317) and private sectors. Insurance coverage alone will not provide the immunization infrastructure necessary to ensure a strong evidence base for national vaccine programs and policy, quality assurance for immunization services, and high vaccination coverage rates across the lifespan.

*Question.* In 2012, \$190 million from the Prevention and Public Health Fund will be transferred to the section 317 immunization program. How will these funds be used and will those activities continue in 2013 at the same level of support?

*Answer.* In fiscal year 2012, PPHF will meet the needs of the Section 317 Immunization Program, as well as provide one-time resources for infrastructure enhancements in health IT, planning and implementation of public health billing systems, adult vaccination, and capacity for vaccinating school-age children. The fiscal year 2013 budget directs \$25 million toward continued progress in the billables project, but eliminates these other one-time enhancements.

## QUESTIONS SUBMITTED BY SENATOR RON JOHNSON

*Question.* In the Massachusetts Health Insurance Exchange, I understand there is a 6-month period between when an employer drops coverage and when an employee is eligible for participation in the exchange. Is there any similar provision in Obamacare?

*Answer.* In Massachusetts, an individual is not eligible for subsidized coverage if offered employer-sponsored insurance within the last 6 months. The employer offer must meet certain benchmarks and the Board can waive the 6-month requirement (956 CMR 3.05). There is no similar 6-month waiting period in the Affordable Care Act.

*Question.* In the various analyses conducted by the Department of Health and Human Services (HHS) or the Centers for Medicare & Medicaid Services on employer behavior related to employer sponsored insurance, is this significant difference in policy taken into account?

*Answer.* The Affordable Care Act does not include the same requirements as the Massachusetts law, and the Department has not examined the differences. Congressional Budget Office (CBO) and the Joint Committee on Taxation recently released updated estimates of the potential impact of the Affordable Care Act on coverage. The report shows that the Affordable Care Act is estimated to reduce the number of nonelderly people without health insurance by 30 million to 33 million in 2016 and subsequent years.

*Question.* Are other differences in the Massachusetts model taken into account? If so, which ones. If not, why not?

*Answer.* HHS is charged with implementing the Affordable Care Act and not a State law. Estimates of the impact reflect analysis of the Federal law only.

*Question.* How much will HHS spend on health insurance exchanges, in total, from the time the healthcare bill was signed into law until 2014 when the exchanges are supposed to be fully operational?

*Answer.* Our current baseline for Exchange Planning and Establishment Grants estimates that we will obligate approximately \$2.5 billion from when the law was enacted until fiscal year 2014 and that we will outlay \$2 billion during that timeframe.

Through the end of fiscal year 2011, HHS had obligated approximately \$100 million to implement the federally facilitated exchange as well as carry out the Secretary's responsibilities on behalf of all exchanges. The fiscal year 2013 President's budget requests an additional \$864 million for the Department's exchange-related responsibilities to prepare for the opening of exchanges in January 2014.

*Question.* Please describe a realistic timeline for HHS to establish Essential Health Benefits, Health Information Exchanges, and State and Federal Insurance Exchanges?

*Answer.* The establishment of the exchanges is a complex and resource-intensive process. We believe it is realistic to have an exchange operating in every State in time for open enrollment beginning on October 1, 2013, for plan year 2014. The Department is currently working to provide additional information on Essential Health Benefits in the coming months, so that States and health insurance issuers have information available to prepare for plan year 2014.

The State Health Information Exchange (HIE) program promotes innovative approaches to the secure exchange of health information within and across States and ensures that healthcare providers and hospitals meet national standards and meaningful use requirements. Fifty-six States, eligible territories, and qualified State Designated Entities received awards under this program. In fiscal year 2011, all recipients received approval of their implementation plans for achieving statewide health information exchange. Recipients are currently continuing to execute these plans and improve health information exchange in their localities.

*Question.* How does HHS plan on addressing the low income individuals who will frequently alternate between insurance through an exchange and Medicaid?

*Answer.* HHS recognizes the potential for movement of individuals between the exchange and Medicaid. Our goal is to ensure the accuracy of eligibility determinations to achieve a seamless transition experience for individuals with changes in circumstances that cause their program eligibility to change between the exchange and Medicaid. To this end, the verification and eligibility determination processes for exchanges will be designed to parallel and integrate with those in Medicaid and Children's Health Insurance Program (CHIP). The exchange will coordinate with Medicaid and CHIP to ensure that an applicant experiences a seamless eligibility and enrollment process regardless of where he or she submits an application.

To the extent that individual's circumstances change, section 155.330 of the exchange proposed rule establishes standards for eligibility redeterminations during a

benefit year. Exchanges must redetermine eligibility if they receive and verify information either reported by an enrollee or through electronic data matching. In an effort to identify changes quickly, this section proposes to require enrollees to report changes in circumstances that affect eligibility within 30 days of such a change.

*Question.* If HHS does not have a plan for these individuals, why not?

Answer. HHS recognizes the potential for movement of individuals between the exchange and Medicaid. Our goal is to ensure the accuracy of eligibility determinations to achieve a seamless transition experience for individuals with changes in circumstances that cause their program eligibility to change between the exchange and Medicaid. To this end, the verification and eligibility determination processes for exchanges will be designed to parallel and integrate with those in Medicaid and CHIP. The exchange will coordinate with Medicaid and CHIP to ensure that an applicant experiences a seamless eligibility and enrollment process regardless of where he or she submits an application.

To the extent that individual's circumstances change, section 155.330 of the exchange proposed rule establishes standards for eligibility redeterminations during a benefit year. Exchanges must redetermine eligibility if they receive and verify information either reported by an enrollee or through electronic data matching. In an effort to identify changes quickly, this section proposes to require enrollees to report changes in circumstances that affect eligibility within 30 days of such a change.

*Question.* What funding does HHS plan on using to establish State-level exchanges for the States that refuse to establish their own exchange?

Answer. In fiscal year 2012, CMS will use a combination of administrative funding and the Implementation Fund for Exchanges. In fiscal year 2013, the President's budget requests additional funding in the CMS Program Management account for programmatic and administrative activities necessary to prepare for exchange open enrollment beginning October 1, 2013. CMS anticipates collecting user fees in fiscal year 2014 to begin offsetting some of the operational costs of the federally facilitated exchange.

*Question.* Please describe the HHS Federal exchange model, also describe how will it be different from an inter-State exchange?

Answer. Specific details about the federally facilitated exchange will be released through guidance to States and other stakeholders in the coming months. Although there are opportunities for States to participate in the federally facilitated exchange, such as through a Partnership Exchange, the ultimate responsibility for operations will remain with the Federal Government. An inter-State exchange would share functions, such as a call center and financial management, across states in a manner similar to the federally facilitated exchange, but in this case the States involved are responsible for the exchange operations.

*Question.* In addition to this mandatory money for State-based health insurance exchanges, the President's 2013 budget requests an additional \$864 million for the Federal exchange and other exchange activities. How will this money specifically be spent and how will the Federal exchange differ in functionality from the web portal HHS has already implemented?

Answer. As with the State-based exchanges, fiscal year 2013 is the year many operations of the federally facilitated exchange begin, as CMS will need to be prepared for open enrollment on October 1, 2013, the first day of fiscal year 2014. The majority of the \$864 million request for CMS' exchange work is related to operations and management of the federally facilitated exchange with some funding to support the Secretary's duties on behalf of all exchanges. Specifically, \$574.5 million of the total will be used for exchange operations and management including eligibility and enrollment functions, certifying health insurance plans as qualified to be sold through the exchange, as well as oversight of plans and State-based exchanges. The additional \$289.5 million will be used for consumer education and outreach activities, such as a call center, to help consumers understand their new options under the Affordable Care Act and to fund navigators and in-person enrollment assistance to facilitate the enrollment process.

Healthcare.gov is a useful tool for providing information on potential sources of insurance available to individuals today, and HHS can leverage its capabilities for presenting information to assist consumers in comparing across plans in exchanges. The federally facilitated exchange will go beyond what is available through Healthcare.gov by certifying that the plans offered meet certain standards of quality and benefits. The federally facilitated exchange will also perform eligibility determinations, enroll individuals into plans, and provide for in-person or call center support to answer questions about available coverage.

*Question.* How does HHS plan on integrating the necessary private information needed from the Internal Revenue Service (IRS), HHS, Department of Homeland Se-

curity (DHS), Social Security, and patient medical records while ensuring that the data is up-to-date and remains private?

Answer. Protecting the privacy and confidentiality of personal health information is among our highest priorities. The Department has a long and successful history of doing so in the Medicare program. The minimum functions that an exchange must perform do not require or necessitate the collection of medical records of individuals who purchase coverage through the exchange. In response to concerns regarding privacy of personal health information of individuals enrolling in exchanges and Medicaid, the final exchange rule will address privacy and security standards for personally identifiable information that exchanges must establish and follow in more depth than previously discussed.

Section 1413 of the Affordable Care Act outlines a series of data exchanges through secure interfaces that will facilitate eligibility determinations for enrollment in a qualified health plan (QHP) in the exchange and insurance affordability programs in a timely manner. To assist in these operations HHS has contracted for support in building a data services hub that will provide critical IT functions to every exchange. The hub will act as a single interface point for exchanges to Federal agency partners, minimizing the burden on states in exchanging information with Federal agencies. The hub will enable a streamlined, secure, and interactive customer experience that will maximize automation and real-time adjudication to the extent possible while protecting privacy and personally identifiable information.

*Question.* What database will be established to handle this data?

Answer. HHS is not establishing a database to facilitate eligibility determinations. Data will not be held by HHS. Instead, as described above HHS, through the data services hub will facilitate the exchange of data between Federal agencies and exchanges necessary to determine eligibility for enrollment in a QHP through the exchange and for insurance affordability programs.

*Question.* What progress has been made and what portion of the budget has been allocated to ensure this integration and confidential data are protected?

Answer. Protecting the privacy and confidentiality of data is among our highest priorities. In response to concerns regarding privacy of personal health information of individuals enrolling in exchanges and Medicaid, the final exchange rule will address privacy and security standards for personally identifiable information that exchanges must establish and follow in more depth than previously discussed.

As we implement exchanges working with our State partners we will use the provisions of the final regulation along with other applicable statutes to ensure the privacy and confidentiality of data.

*Question.* The healthcare law included a \$1 billion implementation fund. In order for the Congress to better evaluate the administration's request for additional funds for implementation activities, please provide an accounting of how the monies provided pursuant to the new healthcare law have been expended. As part of your answer, please include a comprehensive breakdown of spending by department and subsidiary administrative units, as well as by function.

Answer. The following table displays the spending from the Health Insurance Reform Implementation Fund as of February 29, 2012, by agency:

Organization	Obligations	Outlays
Internal Revenue Service .....	\$213,264,945	\$154,181,697
Office of Personnel Management .....	2,938,850	1,442,102
Department of Labor .....	3,055,102	2,958,880
Department of Health and Human Services .....	251,742,492	134,917,483
Total, Health Reform Implementation Fund .....	471,001,389	293,500,162

HHS uses these funds to implement Medicare and Medicaid changes required in the ACA, including closing the Part D coverage gap and developing new value-based purchasing models for Medicare providers. HHS has also used these funds to plan and prepare for the establishment of State-based and federally facilitated exchanges as required in the ACA.

The Office of Personnel Management uses funding to plan for implementing and overseeing the establishment of at least two Multi-State Plan Options to be offered on each State health insurance exchange beginning in 2014, and allowing tribes and tribal organizations to purchase Federal health and life insurance for their employees.

The Department of the Treasury uses funding to implement multiple tax changes from the Affordable Care Act, including the Small Business Tax Credit, expanded

adoption credit, W-2 changes for loan forgiveness, excise tax on indoor tanning services, charitable hospital requirements, and plan for exchanges.

The Department of Labor uses funds to conduct compliance assistance; modify or develop IT systems that support data collection, reporting, policy, and research; and develop infrastructure for the newly required Multiple Entity Welfare Arrangements reporting and registration within the Affordable Care Act.

Of the \$251,742,492 obligated by HHS to date, approximately 13 percent has paid for personnel, 84 percent has supported contractual services, and 3 percent has been obligated for rent, supplies, or other miscellaneous services.

*Question.* The Department of Health and Human Services Budget (HHS budget) calls for 76,341 employees in fiscal year 2013. This is an increase of nearly 1,400 employees over the fiscal year 2012 level. How many of these employees will have responsibilities covered under the new healthcare law?

*Answer.* The fiscal year 2013 President's budget requests an increase of 136 FTEs more than the fiscal year 2012 appropriated level for ACA related activities.

*Question.* How many staff members are currently working at the Center for Consumer Information and Insurance Oversight (CCIIO)? Please provide numbers for both full-time and part-time staff separately. How many staff do you expect will be working at CCIIO at the end of fiscal year 2012? How many staff do you expect will be working at CCIIO at the end of fiscal year 2013?

*Answer.* As of March 10, 2012, CCIIO has approximately 261 employees on-board. 258 employees are considered full-time, and 3 employees are considered part-time. This staff is supported by a combination of discretionary funds and mandatory ACA funding. By the end of fiscal year 2012, CMS expects to consume 450 FTEs on CCIIO-related activities. This staffing level will grow to a projected 710 FTEs by the end of fiscal year 2013 as we bring the exchanges online.

*Question.* How does HHS account for the \$111 billion increase in mandatory spending for health insurance exchange tax credit between fiscal year 2014–2021? Please provide a full itemized breakdown.

*Answer.* Premium tax credits for individuals enrolled in qualified health plans are under the jurisdiction of the Department of the Treasury, so HHS did not provide the estimates of the tax credits in the President's budget referenced in the question.

HHS understands from the Department of the Treasury that approximately one-half of the \$111 billion increase for premium tax credits related to exchanges results from legislative changes enacted in 2011, primarily Public Law 112–56, which changed the definition of modified-adjusted gross income to include certain Social Security income. This legislative change resulted in shifting individuals previously eligible for Medicaid into the exchange premium tax credits. The remaining difference is attributable to technical changes to Treasury's revenue estimating model that are designed to improve its overall accuracy. Those changes impact all income tax modeling and were not implemented just for purposes of calculating the cost of the premium tax credit. One example of the technical changes involves the projection of the distribution of income, which resulted in the composition of families projected to claim premium tax credits being somewhat older and lower-income than previously projected. These changes do not reflect fundamental changes in assumptions regarding utilization of premium tax credits or the cost of providing coverage for a given person in the exchanges.

*Question.* Please describe how the programs funded under section 4002 of PPACA are being measured to determine their efficacy. As part of your answer, please indicate whether and how each program is evaluated to determine how it improves health outcomes for identified individuals and reduces healthcare expenditures.

*Answer.* HHS strives to ensure that programs funded by PPHF are making the greatest health impacts. Within the programs, the Department assigns a trained project officer to monitor and advise each grantee. Project officers provide ongoing consultation and oversight to grantees regarding program performance.

Project officers also conduct site visits in order to objectively validate information and actively resolve challenges that a grantee is facing in order to ensure that the goals of the project are achieved.

Programmatic performance measures also have been developed for each PPHF funded program at three levels:

- performance milestones for start-up;
- short-term impact; and
- long-term objectives.

All PPHF-funded programs report twice a year regarding the status of established milestones and measures.

HHS leaders regularly review these performance data to ensure that programs are on track and accountable for the outcomes associated with each investment.

## QUESTION SUBMITTED BY SENATOR JERRY MORAN

## MEDICARE PART D PREFERRED NETWORK PHARMACY PLANS

*Question.* Last year, Centers for Medicare & Medicaid Services (CMS) allowed insurers to partner with large chain drug retailers to launch a preferred network Part D pharmacy plan. Similar plans were rolled out at the end of 2011. These plans can offer prescription drugs to Medicare beneficiaries at significantly reduced prices compared to other Part D plans.

It is important that these preferred network plans, and all Part D plans, are accurately marketed to Medicare beneficiaries so they are able to fully understand the features of the various plans and the benefits and drawbacks of signing up for one plan compared to another.

Many seniors get their medications and related counsel from a trusted pharmacist in their community. The preferred pharmacies in the preferred network plans, Part D agents and brokers, and representatives of the Senior Health Insurance Information Program should disclose to Medicare beneficiaries that the beneficiaries may have to go to a specific preferred pharmacy provider to access the most reduced drug costs advertised by such plans.

If Part D plans are not accurately marketed, pharmacy access for rural Americans could be jeopardized. If a Part D plan limits Medicare beneficiaries to only a small number of pharmacy providers to get the most reduced drug prices, it is important that this information be clearly disclosed to them. Additionally, it is important that the Medicare Plan Finder contain obvious information for beneficiaries regarding such pharmacy provider options as well as costs.

What actions is CMS taking to ensure accurate marketing and full disclosure of Part D preferred network plans for the 2013 plan year?

*Answer.* An increasing number of Part D plans offer cost-sharing differentials between preferred and nonpreferred network pharmacies. It is important to ensure that beneficiaries understand whether preferred cost sharing is available at individual pharmacies. Specifically, confusion may arise if beneficiaries do not select a pharmacy when they compare Part D plans using the Medicare Plan Finder. Therefore, we are currently working to change the Plan Finder to require each beneficiary to select a pharmacy in his/her plan's network for purposes of providing cost estimates that reflect the selected pharmacy's preferred or nonpreferred status in the plan's network. We believe this change will eliminate the possibility that a beneficiary will obtain cost estimates and plan selections based on preferred pharmacy cost sharing when that beneficiary does not intend to use pharmacies in the preferred pharmacy network. The selection of a particular pharmacy in Plan Finder for this purpose has no bearing on the beneficiary's ability to fill prescriptions at any network pharmacy.

## SUBCOMMITTEE RECESS

Senator HARKIN. Thank you, Madam Secretary.

The record will stay open for 1 week for additional input from members of this subcommittee.

The subcommittee will stand in recess.

[Whereupon, at 11:45 a.m., Wednesday, March 7, the subcommittee was recessed, to reconvene at 10:30 a.m., Wednesday, March 14.]