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RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

June 5, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20101

Dear Madam Secretary:

Thank you for appearing before the Subcommittee on Health on Thursday, April 18, 2013 to testify at the hearing entitled "A Financial Review of the Department of Health and Human Services and Its FY 2014 Budget."

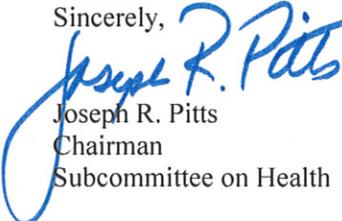
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Wednesday, June 19, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at Sydne.Harwick@mail.house.gov and mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Would you support legislation that places HHS employees in the exchanges?
2. As you know GAO and MedPAC have examined the in-office ancillary Service Exception in depth and neither group has recommended repealing IOASE. I am concerned that the Administration's proposal would result in more patients receiving care in the more expensive hospital setting, thus undermining an integrated delivery of care and lead to more hospital acquisitions of physician practices.

Would you provide the quantitative analysis that supports the \$6 billion score for the proposal? How much is attributable to each service?

3. With regard to radiation, are you aware that radiation utilization from 2007-2011 has been flat at the precise time physician offices have acquired the IMRT technology? Doesn't that suggest that there would be no savings from prohibiting physician ownership of radiation?
4. The President's budget would equalize payment rates for certain conditions that can be treated in both rehabilitation facilities and skilled nursing facilities. In the budget brief, this balancing of payment rates is described as "improving financial incentives to encourage efficient and appropriate provision of care by reducing the disparity in Medicare payment rates between settings." Please explain what the President hopes to accomplish by this?
5. The proposed budget would also implement bundled payments - beginning in 2018 - for post-acute care providers including long term care hospitals, and home health providers. Has your department already begun work to prepare for implementation and, if so, would you please describe such work? If not, how do you envision such a roll out in 2018?
6. Today, hospitals receive reimbursement from the federal government for bad debts. Changes were made in PPACA to lower that amount to 65% of the total bad debt amount a hospital incurs. The proposed budget would seek to further reduce this amount by 25% (to 40%). Can you explain the rationale behind this change?
7. The Office of Management and Budget (OMB) directed all federal agencies to "use any available flexibility to reduce operational risks and minimize impacts on the agency's core mission in service of the American people" and to "identify and address operational challenges that could potentially have a significant deleterious effect on the agency's mission or otherwise raise life, safety, or health concerns."

On what legal opinion did HHS base its decision to apply the 2 percent cut to ASP?

8. Does HHS believe applying the sequester three times to an oncologist's payments will raise life, safety or health concerns? If so, why hasn't HHS used its discretion to modify the sequester with respect to reimbursement for cancer treatment?
9. Open enrollment in the Health Insurance Marketplace (State Exchanges) begins October 1, 2013. Will individuals shopping in these state marketplaces have complete transparency to and the ability to compare options for cost and availability of medical and pharmaceutical coverage?

10. In response to reports from AHRQ and MedPAC regarding the health savings generated by Comprehensive Medication Management and Medication Therapy Management (CMM/MTM), will HHS commit to supporting a CMM/MTM component within Medicare?
11. Your administration has raised many expectations that PPACA will improve the health of Americans, because health insurance will improve access to health care. An important factor in healthcare access and delivery is the size of the healthcare workforce which is currently inadequate. Would you explain why in the proposed HRSA budget, funding for Health Workforce and Children's Hospital GME has been reduced? And, would you explain who will provide the care in all those new community health centers that will be funded?
12. In the proposed HHS budget, the discretionary funding for the Vaccines for Children and the Breast and Cervical Cancer Program is reduced to reflect expanded access to health insurance. Yet funding increased for other programs, such as Ryan White and Family Planning that will also be affected by the expansion. Would you explain why, in this fiscal environment, these programs were not only spared from cuts, but received increases?
13. To the American public and Congress, the Prevention and Public Health Funds appears like your own personal slush fund. Since 2010, we learned that the first wave of funding was used by States to fund lobbying, park signage, dog neutering, and other questionable activities. By 2012, the fund has morphed into a budgetary tool to prop up discretionary programs or Obamacare implementation. Instead, would you support directing these funds to help patients with pre-existing conditions? Don't these Americans deserve to get the relief that this administration promised them?
14. Our nation continues to face serious national security threats, and the need remains to protect the American people against chemical, biological, radiological and nuclear (CBRN) events. What impact has the availability of the Project BioShield Special Reserve Fund had on the development and procurement of medical countermeasures for national security threats over the past decade?
15. We are losing the fight against drug resistant pathogens. Our current antibiotic armamentarium is low and not regenerating fast enough. In the President's budget proposal, BARDA acknowledged this and is interested in helping advance new products. But manufacturers are fleeing the business, and only a few major companies are working in the field—it just doesn't make fiscal sense: the drugs are used infrequently—a good thing to keep resistance in check—and are meant to eradicate a pathogen in only a few doses. The FDA is putting in tremendous work to speed up product development, but what else can we be doing to further this critical therapeutic arena?
16. In August 2012, CDC found that three-fourths of all persons infected with Hepatitis-C are among the baby boom birth cohorts, with the vast majority unaware of their infection, and recommended that every boomer get screened once in their life regardless of risk factors (risk based screening was deemed of "limited success.") Meanwhile a sister agency, USPSTF, issued its draft guidelines for HCV screening that wants to continue on using risk-based screening and ignores the high density of HCV positive people in the baby boom generation. HCV costs are about to explode on Medicare—even though it's easy to test and then treat these populations, with new treatments literally curing people of the disease—and the ACA requires health plans to follow the USPSTF guidelines, and HHS does not seem ready. What is the Department doing to navigate and head off this looming medical and fiscal crisis?
17. The President's Budget proposal uses language suggesting ACA expansion efforts will take over much of the medical services of HIV patients, currently provided under Ryan White programs, ostensibly freeing up federal support for ancillary services for HIV patients—but what are the actual funding needs of this population, how should funds be used appropriately? What is HHS doing to help Ryan White grantees become federally qualified health centers to help beneficiaries in providing health services after ACA implementation?

The Honorable Joe Barton

1. Given recent reports from China about what could be a very serious emerging threat from a new flu virus, how will the Department of Health and Human Services (HHS) make sure its recently awarded Centers for Innovation and Advanced Manufacturing are fully utilized, including removing any unnecessary burdens from bureaucratic processes within the Assistant Secretary for Preparedness and Response (ASPR) office that seem to plague other similar contracts?
2. I am routinely informed that the contracting function handled by the office of the Assistant Secretary for Preparedness and Response is inefficient and lacks transparency. This has not only delayed procurement of needed medical countermeasures but also results in wasted effort, increased expense and deterred participation. What can HHS do to improve the performance by the contracting office within ASPR?
3. HHS has the authority under the recently reauthorized Pandemic and All Hazards Preparedness Act to use "other transaction authority" to allow contracts to run more efficiently. It has had this authority since 2006, yet has never used it. The Department of Defense (DOD) has similar authority and has used it to great effect. Why has HHS not used this authority? Aren't the new Centers for Innovation and Advanced Manufacturing precisely the type of effort that should be conducted under Other Transaction Authority? Has this been considered?

The Honorable Ed Whitfield

1. For the past two years, about 100 bipartisan Members of Congress have signed a letter in support of the NDPP because it is one of the most innovative, evidence-based models we have to prevent a disease that is expected to impact one in two adults by the end of this decade. It has been estimated that this program could save the nation between \$100-\$191 billion over the next decade. That said, it is not mentioned in your FY 2014 budget. Can you please explain the decision to not fund this important public-private partnership that will teach people personal responsibility while bending the cost curve?
2. The Centers for Medicare and Medicaid Services (CMS) currently covers the fasting blood glucose test and oral glucose tolerance test to screen for diabetes in Medicare enrollees at risk for diabetes or those already diagnosed with prediabetes. However, physicians and other primary care providers are finding that the A1C test is actually the most convenient way to screen patients for diabetes. In a letter to Senator Hagan in December 2011, you said that "this test has been recommended by the ADA for diagnosis and is under consideration by CMS for coverage by Medicare." Yet, in 2013, CMS does not cover the cost of an A1C test for purposes of screening. What can be done to encourage use of the A1C test for screening?
3. I thank the CDC's Division of Diabetes Translation for releasing the first-ever Diabetes Report Card in 2012. This initial Diabetes Report Card is a baseline, and law requires it to be updated every two years and to include national and state trend data. In light of continual improvement, areas that could be expanded include additional data on gestational and undiagnosed diabetes (including state data), inclusion of average A1c level data trends among individuals with diagnosed diabetes, and the mention of Medical Nutrition Therapy counseling as a Medicare benefit proven to positively impact diabetes outcomes. How can we work with you to continue to improve the Report Card before it is next issued in 2014?
4. As you know, this Committee has been very concerned about CDC grantees using CPPW funds to engage in activity to change laws and regulations at the state and local level. Unfortunately, CDC grantees across the country appear to be continuing to engage in similar activity with PPHF funds.

For example, the State of Minnesota advised its CTG grantees that their Community Transformation Grant (CTG) funds could be used to make changes to state ordinances. A Q & A document available on the State's website reads "...a CTG strategy could include updating the ordinance to increase the price of tobacco retail licenses to pay for the program..." Similarly, the County of Fairfax, Virginia includes the following CTG strategy on its website, "increase the tax on packs of cigarettes purchased in Fairfax County". Houston/Harris County, Texas encouraged their CTG sub-grantees to "limit density of fast food outlets and other outlets featuring high calorie, high sodium, and low nutrition foods" through "zoning: regulate the number of fast food restaurants in a given area."

In order to fulfill our Congressional oversight responsibilities, I would like to respectfully request the following documents in relation to the CDC grants identified in Appendix A in the document attached to this letter:

- copies of all documents associated with the grants, whether competed or not, solicited or unsolicited, including your proposals and award documents.
- copies of the grant program files pertaining to the funded activities, including but not limited to budget detail and worksheets and regular progress reports including narratives, budget information and all correspondence with CDC grantees and subgrantees regarding the intent, purpose and use of the grant dollars.
- copies of all communications involving or by grantees or subgrantees, describing meetings or correspondence with public officials at the state and local level.
- copies of all materials received re training, educating and monitoring grantees' use of the grant, including Powerpoint presentations, background preparatory materials and memoranda describing the programmatic goals and success of changing laws and policies at the state and local level.
- copies of all materials addressing or analyzing whether grantees or subgrantees have violated any anti-lobbying statutes (*e.g.*, 18 USC §1913; 31 USC §1352(a), appropriations bills (www.gpo.gov/fdsys/pkg/BILLS-111hr3288enr/pdf/BILLS-111hr3288enr.pdf) or administrative regulations (*e.g.*, AR-12).
- copies of all materials addressing proposed or actual remedies for violating anti-lobbying statutes or regulations, including all materials describing or listing grantees or subgrantees that have violated anti-lobbying statutes or regulations.
- Copies of any correspondence or notes regarding minutes of meetings or public or private reports describing the intent, purpose and use of the grant dollars, including any reference to descriptions of activity involving efforts to change policy, laws, regulations at the state and local government level.

The Honorable Mike Rogers

1. Recently, we have had some frightening reminders of the threats we continue to face in this country. The bombs in Boston and the ricin laced letter addressed to our Senate colleague and President Obama demonstrate that we must remain committed to preparing for the threats we know about, as well as build capacity to respond to those we cannot anticipate.

In that vein, reauthorizing the Pandemic and All-Hazards Preparedness Act (PAHPA) was a top priority for the Committee over the last two years. One of the key components of the recently enacted legislation is a provision to reauthorize the Project BioShield Special Reserve Fund (SRF) at \$2.8 billion to be available for the next 5 years. The SRF was originally created as a guaranteed market incentive to encourage companies to develop and produce medicines and vaccines to protect Americans from identified threats, since there is no commercial demand for these products.

I am very concerned by the level of funding provided to the SRF in the President's Budget. Shifting to an annual appropriation, and at only \$250 million, would create extreme uncertainty in the medical

countermeasures market. The funding provided is not even one fifth of the five year authorized level of \$2.8 billion and is less than many individual BioShield procurement contracts. In addition, the new multi-year contracting language is NOT sufficient to make up for the lack of funds.

In your professional opinion, what has been the impact of the Project BioShield Special Reserve Fund over the last 10 years? How will you ensure that the Project BioShield Special Reserve Fund is available for the next 5 years to give confidence to the pharmaceutical and biotechnology companies that are developing and delivering essential medicines to our national stockpile?

The Honorable Michael C. Burgess

1. The Administration's proposed budget includes legislative proposals pertaining to rehabilitation hospitals, one of which seeks to pay rehabilitation hospitals nursing home-based rates for certain conditions because, according to the President's budget, IRFs are services that "may not be appropriate" for certain conditions. A second proposal would elevate the IRF "60% Rule" to a "75% Rule" to "ensure that [IRFs] are classified appropriately."

As you know, Medicare expenditures for IRF services have remained relatively flat for the past 6 years, the number of IRFs is not increasing, and the number of beneficiaries treated in IRFs is not growing faster than the overall growth in Medicare beneficiaries. What specific data or evidence does HHS have to justify support for these proposals?

2. If either or both of these proposals were adopted by Congress, more Medicare beneficiaries would be shifted into nursing homes. In light of repeated concerns expressed by the HHS-OIG, MedPAC, and CMS that Medicare may be overpaying nursing homes for rehabilitation and therapy services, why would Congress enact policies that would effectively compound the problems underlying these concerns, especially without quality and outcomes measurements in place to ensure that beneficiaries are not receiving substandard care in a nursing home, relative to what they would receive in an IRF?
3. In the past your agency has stated its priority to ensure diversity in the health professions as well as to ensuring health professionals practice in underserved communities. How do the cuts to Title VII in the agency's FY 2014 budget, which eliminate these programs, achieve the agency's diversity objectives and increase the number of diversity of health professions?
4. NIH has recently acknowledged problems with the availability of resources for awarding minorities with R01 grants. How will your agency deal with this issue in the midst of your proposed cuts to the Research Centers at Minority Institutions (RCMI) program at NIH's National Institute on Minority Health and Health Disparities program in the FY 2014 budget?
5. In regards to molecular pathology services in Medicare, CMS eliminated stacking payment codes last year in favor of a re-pricing process called "gap-fill" to establish pricing for these services. While these molecular tests provide the foundation for personalized medicine, the gap-fill process has resulted in a lack of transparency, prices below the cost of providing some tests, and unnecessary delays in payments from the MAC's to clinical labs.

Would you please provide the Committee with a status report on the gap-fill process to date, in addition to what steps CMS plans to take to improve the gap-fill process in the near future to ensure adequate Medicare beneficiary access to molecular pathology services?

The Honorable Phil Gingrey

1. Why does the budget propose excluding certain services from the in-office ancillary services exemption (IOASE) when both the GAO and MedPAC reviewed the exception and did not recommend closing it?
2. Recent MedPAC data suggests that the growth of advanced diagnostic imaging services has slowed in recent years. If this is the case, why does this budget include provisions to eliminate imaging services from the in-office ancillary services exception?
3. How are the “accountability standards” defined that would allow providers to continue providing services under the IOASE?
4. The ability for physicians to provide ancillary services in the office setting achieves both lower cost treatment and increased care coordination. Are you concerned that closing the IOASE will result in higher costs and fragmented patient care?
5. As an obstetrician and gynecologist, I know how important it is for OBGYNs to have up-to-date nutrition advice based on the latest science, and doctors look to FDA for that advice. Unfortunately, FDA’s advice to pregnant women on seafood consumption is far outdated, leaving expectant mothers with old information that has resulted in a decline in seafood consumption to the detriment of fetal development. You’ve been saying for over two years that the advisory to pregnant women on seafood consumption will be updated. As FDA continues to miss deadlines for releasing the advice, it is time that you personally engage in the finalization process to get this advice out. Would you provide an update on the seafood advisory’s status and commit to completing the final advice by this summer?

The Honorable Cathy McMorris Rodgers

1. This Committee has spent a great deal of time reforming the way pharmacies are paid for generic drugs in the Medicaid program.

The Deficit Reduction Act, and later the Affordable Care Act, established that Average Manufacturer Price (AMP) would be used to set Medicaid Federal Upper Limits (FULs) for pharmacy reimbursement. Because AMP has never been used in this manner, Congress gave CMS flexibility to increase the multiplier to calculate FULs, should they prove to provide insufficient payment to retail pharmacies.

As you know, CMS has been publishing AMP—based FULs in draft form on a monthly basis, and the pharmacies in my district/state tell me that the FULs change dramatically in value from month to month, and that in many cases they are below pharmacy’s cost to purchase these medications.

Given this is a new reimbursement model that has yet to be fully tested in the marketplace; it seems premature to make any changes.

Consequently, I was surprised to see the provision in the president’s budget, “Lower Drug Costs” that alters the way FULs are to be calculated. I am also surprised that CMS has chosen to ignore the authority granted by Congress to increase the multiplier to calculate FULs if necessary. Why has the Administration proposed this change to the calculation of FULs?

What portion of the \$8.8 billion in savings from this budget provision is attributed to reduced pharmacy payments?

Why has CMS chosen to disregard the authority provided by Congress to increase the multiplier to set Federal Upper Limits, even on a case by case basis?

2. Under the mandate requiring all insurance plans cover sterilization and contraception including the morning-after and week-after pills, many non-profits and family owned businesses will no longer be able to operate in keeping with their principles and values, while also offering health insurance to their employees. Because you have not provided an exemption that fully respects religious freedom, over 160 plaintiffs have filed suit against this mandate—seeking the courts grant them relief from the mandate that infringes of their fundamental Constitutional rights. The family owned business' cases are moving forward, but the non-profits' cases are delayed until a final rule is issued. Since both the advance notice of proposed rulemaking and the proposed rule have been similarly rejected by religious objectors, they have little hope that the final rule will address their concerns. Therefore, they expect to be forced to rely on relief in court. However, their cases cannot move forward until the rule is finalized.

Faith-based charities, hospitals and schools are still waiting for their day in court, waiting for a final rule, and time is running out for them—they must comply starting August 1st of this year with the mandate or face ruinous fines. When will HHS issue the final rule, so that these faith-based charities, hospitals and schools who want to provide good health care to their employees and continue to keep that health care in line with their deeply held beliefs can go to court and protect their religious liberty?

As I mentioned previously, Americans have been seeking redress through the courts because the administration continues to push forward a rule that violates deeply held moral and religious beliefs. In issuing a final rule, will you seek to protect the First Amendment rights of all Americans?

The Honorable Leonard Lance

1. Much has been made about the issue of drug rebates to the Medicare program. This committee has done much work in exploring the ways in which Medicare Part D drugs have kept down costs in the Medicare program. In proposing to apply Medicare drug rebates to the Medicare program, did your office conduct an analysis to ascertain what impact on innovation or access these rebates might have?
2. The proposed budget would seek to expand Medicare claims data sharing with qualified entities for such purposes as fraud prevention. Would you explain how this policy would work?
3. Citing concerns with the way CMS has handled fraud prevention to date, and alarmed by the tens of billions CMS loses to waste, fraud and abuse each year, this committee recently put out a proposal on its intention to identify and reform the ways in which CMS manages fraud prevention. Yet the President's budget would request that fraud prevention funding in 2015 be mandatory and fall outside of Congressional oversight. Would you explain how giving CMS more autonomy with regards to fraud funding will help address concerns on capitol hill that CMS is not properly conducting fraud prevention in the Medicare and Medicaid programs?

The Honorable Bill Cassidy

1. In 2006, government-funded patient advocates coached schizophrenic William Bruce to say the right things in order to be released from a psychiatric facility- despite his doctor's recommendation. Two months later, he murdered his mother with a hatchet. Today, he is receiving effective treatment (including medication) and lives in a state psychiatric facility. (See "A Death in the Family" in the WSJ). He is quoted as saying of the advocates, "They helped me immensely with getting out of the hospital, so I was very happy (but) the advocates didn't protect me from myself." It seems the patient advocates (who are funded to protect against patient abuse and neglect) do a better job advocating for the irrational and often dangerous voices of the disease than advocating what is in the best interest of the individual. I see the budget will again allocate 36 million to this program. What has been done since the 2006 death of this boy's mother to prevent government funded patient advocates from

coaching seriously mentally ill individuals, who are clearly in need of treatment, to forego it to their detriment, their families and their communities?

2. Assisted Outpatient Treatment (AOT, also known as -outpatient commitment or “OPC”) allows a judge to order an individual with serious mental illness, who is unable to live safely without supervision and treatment, to follow a treatment plan while living in the community. In 2010, NIMH director Thomas Insel wrote, “One of the challenges we face in correcting (the problem of SMI individuals ending up in jail) is the absence of an institution for longer-term, evidence-based care for people with severe mental illness.” With state psychiatric hospital beds being closed every day, AOT not only provides what Insel was describing, but also provides it in a way that allows an individual to remain in the less restrictive setting of his/her community. Unfortunately, lawyers paid by SAMHSA’s PAIMI program actively advocate against programs like AOT despite the fact that the DOJ rates the program as a cost-saver and crime-preventer. While a small subset of people with severe mental illness are at significant risk of committing violent acts (including homicide and suicide) at far higher rates than national averages, research has shown that those with schizophrenia and other severe psychiatric diseases are no more violent than those without SMI if their psychosis is controlled. What is SAMHSA doing to address the needs of seriously mentally ill individuals whose brain disease prevents the person from voluntarily seeking treatment before they end up in the criminal justice system? Please provide a detailed list of SAMHSA funding that has supported implementation of evidence-based AOT/OPC programs over the last ten years. If no funding or limited funding has gone to these programs, please explain why.
3. The President’s budget requests \$1.5 billion in new funding for federal fallback exchanges (FfEs). This includes \$554 million in “education and outreach.” Congress denied the request for \$1 billion additional funding for FfEs in last year’s continuing resolution. Without congress providing these funds, how are you funding federal exchanges? Please provide a detailed accounting chart of what internal accounts the money is coming from.
4. In August 2012, CDC found that three-fourths of all persons infected with Hepatitis-C are among the baby boom birth cohorts, with the vast majority unaware of their infection, and recommended that every boomer get screened once in their life regardless of risk factors (risk based screening was deemed of "limited success.") Meanwhile a sister agency, the U.S. Preventive Services Task Force (USPSTF), issued its draft guidelines for HCV screening that wants to continue on using risk-based screening and ignores the high density of HCV positive people in the baby boom generation. The ACA requires health plans to follow the USPSTF guidelines. HCV costs are about to explode on Medicare—even though it’s easy to test and then treat these populations, with upcoming treatments literally curing people of the disease while safety and efficacy increase. What is the Secretary office doing to navigate and head off this looming medical and fiscal crisis?
5. The President's Budget demonstrates that the ACA will take over much of the medical services of HIV patients, currently provided by Ryan White funded programs. From current levels, by what amount are Ryan White expenditures expected to decline, and how does the Administration intend to devote those 'surplus' dollars to achieve the stated goals of the national HIV strategy, advance public health and reach an AIDs-free generation? If there are 'surplus' funds, are those funds not best deployed on core medical services and infrastructure strengthening in areas where there are growing populations of HIV patients or continued implementation challenges due to resource-poor setting? The Ryan White Treatment Act calls for 75 percent of funds to be devoted to core medical services. Is it the Administration position that this threshold is no longer prudent or necessary?
6. As you know GAO and MedPAC have examined the in-office ancillary Service Exception in depth and neither group has recommended repealing IOASE. I am concerned that the Administration proposal would result in more patients receiving care in the more expensive hospital setting, undermining the integrated delivery of care and leading to more hospital acquisitions of physician

practices. Would you provide the quantitative analysis that supports the \$6 billion score for the proposal? How much is attributable to each service?

With regard to radiation, are you aware that radiation utilization from 2007-2011 has been flat at the precise time physician offices have acquired the IMRT technology? Doesn't that suggest that there would be no savings from prohibiting physician ownership of radiation?

The Honorable H. Morgan Griffith

1. Back in 2011, I asked your former colleague in the Cabinet, EPA Administrator Lisa Jackson, about the impacts of the administration's burdensome regulations would have on my poor and elderly constituents in Southwest Virginia by raising their heating prices. She responded along the lines of that there are programs to help those people. The President proposed to slash the Low Income Home Energy Assistance Program (LIHEAP) by \$650 million from FY12 levels. I cannot fathom how this administration can push through policies that raise energy costs while suggesting that programs like LIHEAP be cut. How will people needing this assistance that have had their energy costs exacerbated by other policies from this administration survive without these LIHEAP funds?

The Honorable Gus Bilirakis

1. First, in CMS's 45-day notice were changes made to the Medicare Advantage (MA) risk adjustment methodology? Do those changes in effect reward private plans for delaying patients' access to disease management programs and do you believe that this payment policy aligns with the President's stated priority, published in his own budget, to implement payment innovations that reward high quality care?
2. Second, I am concerned about further changes to the MA program. Your colleague Ms. Tavenner stated at her Senate confirmation hearing that MA provides high quality coverage to beneficiaries who are satisfied with their coverage. I can say first hand that MA enrollees in Florida, with a penetration rate of 34%, would agree with that statement and truly value their ability to access private plans.
3. HHS's FY2014 budget proposed severe changes to the coding intensity adjustment for MA, raising it from 0.25 percentage points to 0.67 percentage points until the minimum adjustment plateaus at 7.59% in 2018. This is significantly higher than current law; under ATRA the adjustment plateaus at 5.9%. The ATRA increased the 2018 adjustment level over time from what was established under the ACA at a 5.7% adjustment in 2018 and beyond.

In light of ACA's deep funding cuts to the program (most of which have yet to take effect) and the way the proposed cuts included in CMS's draft 45-day notice were found to jeopardize stability within the program (and since have been reevaluated), why does the agency find it prudent to increase the coding intensity adjustment at such an accelerated rate from what we have seen in the past?

4. The Agency's budget also reduces funding to MA employer plans in which about 1 million beneficiaries are currently enrolled. Employers are already stretched thin by strict cost sharing mandates under ACA for their active workforce and the potential buy-up in coverage to meet the EHB requirements in 2014 under the President's health law. What kind of impact could this funding reduction have on employers? Will it result in reduced benefits or potentially impact wages or job creation? Would you agree that this policy does not fulfill the "fundamental compact" the President's rhetoric would indicate he is committed to defend?
5. Do you believe you have such authority to shift funds between HHS accounts to cover expenses related to implementation of the health care law? If so, would you please provide a list of the authorized accounts you believe you have the ability to make such transfers for implementation

purposes? Would you provide an accounting of what funds have been transferred or used for such purposes? Please provide a legal analysis for such authority.

6. Would the Department share a written timeline of what we can expect with respect to upcoming ACA implementation?
7. A number of news articles have noted higher premiums under the ACA. Would you provide your analysis on why this will or will not be the case?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide information for the record. For your convenience, relevant excerpts from the hearing transcript regarding these requests are provided below.

The Honorable Phil Gingrey

1. During the hearing, Dr. Gingrey asked about your comments you made in March during a speech in Philadelphia. During that speech, you stated that "...some men are going to see some higher costs. It's sort of a one to one shift...some of the older customers may see a slight decline, and some of the younger ones are going to see a slight increase. These folds will be moving into a really fully insured product for the first times, so there may be a higher cost associated with getting into that market." You did not address his question about whether you think it is fair that young people will pay higher insurance rates because of this law. Has your department created contingency plans in the event that young people choose to pay the penalty instead of purchasing the insurance that they cannot afford?

The Honorable Bill Cassidy

3. Dr. Cassidy asked if you could accept a 2 percent reduction in your HHS request. Due to time constraints you could not elaborate on your answer that you would not be able to accept a 2 percent reduction. Please explain why you could not accept a 2 percent reduction in your HHS request.