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ONE HUNDRED FOURTEENTH 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

February 24, 2015
MEMORANDUM

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Commerce on Energy and Commerce Democratic Staff

Re: Subcommittee on Health Hearing on "Examining the FY 2016 HHS Budget"

On Thursday, February 26, 2015, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Examining the FY 2016 HHS Budget." The sole witness will be the Honorable Sylvia Burwell, Secretary of the Department of Health and Human Services.

I. PRESIDENT'S BUDGET REQUEST FOR FISCAL YEAR 2016

The President's HHS budget request for FY 2016 totals $1.1 trillion. The Budget proposals taken together would achieve $249.9 billion savings over ten years while ending sequestration. The total budget authority for discretionary programs at HHS would increase by $4.8 billion to $83.8 billion.

The majority of the HHS budget is for mandatory programs and funds health benefits for Medicare, Medicaid, and the extension of the Children's Health Insurance Program (CHIP). The Budget repeals the flawed sustainable growth rate formula in Medicare and replaces it with a more value-based system, similar to the bipartisan, bicameral compromise from last Congress. The Budget assumes a four-year extension of CHIP paid for by an increase in the tobacco tax. Finally, the Budget also demonstrates an ongoing commitment to public health by increasing NIH funding by $1 billion next year.

II. PROPOSED BUDGET FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

A. Medicare

The President's budget saves the Medicare program $423 billion over 10 years and extends the solvency of the Medicare Trust Fund by five years.

The Budget proposes repealing the unworkable SGR and moving towards a value-based health care system. The proposal allows physicians to choose between alternative payment and delivery models and performance-based fee-for-service payments. Legislation repealing and replacing the SGR has bipartisan, bicameral support, and Congress must work to pass it.

The Budget makes the 10 percent Medicare primary care bonus payment program permanent beginning in 2016. The temporary program was included in the ACA to increase access to primary care for seniors. It is currently set to expire at the end of 2015. The Budget proposes including the program in the physician fee schedule in a budget neutral manner. The benefit of enhanced access to primary care is undisputed, and Congress should consider legislation that would make the Medicare primary care bonus payment program permanent.

The President's FY 2016 Budget includes a number of proposals to better target payments to post-acute care providers, and although it has an aggressive timeline could potentially result in improved efficiency and care management. If implemented well The Medicare Payment Advisory Commission (MedPAC) has recommended that services performed in hospital outpatient departments should be reimbursed at the same rate as the same services performed in physicians' offices or ambulatory surgical centers.[1] Ambulatory services have moved from physicians' offices to hospital outpatient departments in recent years. Meanwhile, moving post-acute provider payments to a bundled system is a reform that has long been discussed. The President's proposal for bundled post-acute care would save $9.3 billion over 10 years. By and large, these proposed reductions are in alignment with the MedPAC recommendations.

Additionally, the Budget changes the classification standard for an inpatient rehabilitation facility, raising the requirement from 60 percent to 75 percent of facility patients having to meet certain severity conditions. This is sometimes called the "60% Rule", and this adjustment would save $2.2 billion over 10 years.

The Budget proposes reducing Medicare provider payments for bad debt from 65 percent to 25 percent over the next three years. Bad debt results from beneficiaries not paying their providers deductibles and copays. This proposal would save $31.1 billion over 10 years.

Building on the Government Accountability Office (GAO) work relating to physician self-referral, the President's budget proposes to encourage more appropriate use of ancillary services by prohibiting self-referrals for radiation therapy, therapy services, advanced imaging, and anatomic pathology services except where a practice is clinically integrated unless certain accountability standards were met. The GAO found that physician self-referral for in office ancillary services resulted in over utilization and rapid growth of services of questionable necessity. This proposal would save $6 billion over 10 years.

The Independent Payment Advisory Board (IPAB) is required to recommend policies to Congress to reduce the Medicare per capita growth rate if the growth rate hits a certain target. The President proposes changing the target growth rate for Medicare spending from gross

[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (June 2013) (online at http://www.medpac.gov/documents/reports/jun13_entirereport.pdf).

domestic product plus 1 percent, to gross domestic product plus 0.5 percent starting in 2018. This provision is estimated to save $20.9 billion over 10 years.

Teaching hospitals receive IME payments to reimburse for the costs of training residents that aren't accounted for in traditional graduate medical education payments. The Budget proposes reducing IME payments by 10 percent beginning in 2016 and giving the Secretary authority to use graduate medical education payments to encourage training of primary care doctors and promote high-quality, high-value health care. This proposal saves $16.3 billion over 10 years. Instead of across the board cuts, Congress should consider proposals to make the IME framework more accountable and efficient while continuing to encourage training of primary care doctors and promoting high-quality, high-value health care.

i. Medicare Advantage Proposals

The President's FY 2016 budget proposes two legislative changes that would improve the accuracy of Medicare Advantage payments. As has been recommended by GAO[2], beginning in 2017, The Budget proposes to increase the minimum adjustment for coding intensity from .25 percentage points to .67 percentage points each year until 2021. This would achieve $31 billion in savings over 10 years.

Another proposal identified by MedPAC, would align employer group plan payments with average Medicare Advantage bids in each market ($7.2 billion in savings over 10 years). These proposals will improve payment accuracy and quality in the Medicare Advantage program, and should receive serious consideration from Congress.

ii. Outpatient Prescription Drugs

The Budget would accelerate the provision in the Affordable Care Act (ACA) that closes the prescription drug coverage gap (or so-called "donut hole") for seniors. Prior to the ACA, Medicare Part D beneficiaries were responsible for 100 percent of their drug costs in the coverage gap. The ACA closes the coverage gap by 2020. The President's budget proposes increasing discounts on brand name drugs to 75 percent in 2017, effectively closing the donut hole for brand name drugs three years earlier. This proposal would save $9.4 billion over 10 years. Congress should seriously consider this proposal, which saves money for both seniors and the federal government.

The Budget proposes allowing the HHS Secretary to negotiate with pharmaceutical companies for the cost to Medicare Part D for biologics and high-cost prescription drugs. High drug costs, especially for specialty drugs, are a serious problem, and Congress should work to find solutions.

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[2] Government Accountability Office, *Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments* (March 2013) (online at http://www.gao.gov/assets/660/651712.pdf).

iii. Proposals Affecting Beneficiary Expenses

The President's budget includes a number of proposals that would increase costs on beneficiaries. Extreme caution should be taken in pursuing these proposals as the Medicare population is older, poorer—with 48 percent of beneficiaries below 200 percent of the federal poverty level, [3] and sicker—with 40 percent having three or more chronic conditions—than the general population.[4] The President's budget proposes to further increase Part B and Part D Premiums beginning in 2019, increase the Part B deductible for new enrollees, impose a new surcharge on the Part B premium for beneficiaries with certain Medigap policies, and institute a $100 co-payment per home health episode starting in 2017.

Increasing out-of-pocket costs on beneficiaries could increase spending long-term, if beneficiaries forgo necessary services and as a result use more high-cost, acute care services in the future. Such policies may disproportionately affect lower- and middle-income beneficiaries who are not poor enough for Medicaid, nor have access to employer sponsored retiree health care.[5]

The President's budget extends the Qualified Individual Program (QI) through 2016 at a cost of $975 million over 10 years. The QI program pays Medicare Part B premiums for beneficiaries whose incomes are 120-135 percent of the federal poverty level. Without this program many low-income seniors would not be able to afford health care. While the President's budget proposes a one-year extension of the program, Congress should consider making the program permanent.

B. Medicaid

The President's budget includes a number of new proposals that will improve Medicaid beneficiaries' access to care. The Budget extends for two years the Medicaid primary care payment increase, which reimburses Medicaid doctors performing primary care services at Medicare rates. It also expands the payment increase to include obstetricians, gynecologists, and non-physician practitioners, all of whom often serve as the source of primary care. Enhancing the low Medicaid payment rates increases beneficiaries' access to care. This provision costs $6.3 billion over 10 years. The benefit of enhanced access to primary care is undisputed, and Congress should consider making this payment increase permanent.

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[3] The Henry J. Kaiser Family Foundation, *A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure* (May 2013) (online at http://kff.org/medicare/issue-brief/a-state-by-state-snapshot-of-poverty-among-seniors/).

[4] Centers for Medicare and Medicaid Services, *Chronic Conditions Among Medicare Beneficiaries* (2012) (online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf).

[5] Kaiser Family Foundation, *Medigap Reform: Setting the Context for Understanding Recent Proposals* (Jan. 2013) (online at http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/).

The Budget requires Medicaid to cover preventive health services without cost-sharing for all adult beneficiaries. Notably, the Budget requires Medicaid to cover tobacco cessation services without cost-sharing. This provision brings Medicaid up to the standards required of private insurers by the ACA. This costs $754 million over 10 years.

The Budget also expands access by creating an option for states to provide 12-month continuous eligibility for adults in Medicaid. As incomes fluctuate during the year, beneficiaries must switch from Medicaid to Marketplace coverage and could experience gaps in coverage. This also causes more administrative costs for states, marketplaces, and insurers. Allowing 12-months of continuous eligibility helps to keep people insured and ensure continuity of care.

The FY 2015 Budget permanently extends the option for States to use Express Lane Eligibility (ELE) to simplify enrollment of children in Medicaid and CHIP ($1.2 billion cost over 10 years). ELE allows states to rely on eligibility findings from other assistance programs to determine Medicaid and CHIP eligibility for children or adults, providing administrative efficiencies and preventing families from having to provide the same information to multiple agencies. This is a common-sense idea that reduces bureaucracy and improves access to coverage and should be made permanent this year.

Hospitals that serve a large number of Medicaid and uninsured individuals receive support in the form of Disproportionate Share Hospital payments (DSH payments). The FY 2016 budget retains a proposal to rebase Disproportionate Share Hospital (DSH) allotments for 2025 ($3.3 billion over 10 years). Given that the existing reductions to DSH allotments are just beginning, caution should be taken with any additional extension of reductions in funding that help offset uncompensated care costs.

i. Children's Health Insurance Program (CHIP)

The President's Budget extends CHIP funding for four years through FY 2019 to align with the maintenance of effort requirement that was included in the Affordable Care Act. A four-year extension will help to ensure that families have continuous coverage and allow state governments to plan their budgets. The Budget includes a four-year extension of the Child Enrollment Contingency Fund, which was established for states with higher than expected enrollment, at a cost of $200 million.

The CHIP proposal would also extend the CHIP Performance Bonus Fund for four years ($1.4 billion cost over 10 years). This fund provides incentive payments to states who adopt program simplifications and also exceed performance benchmarks for enrollment of the lowest income children. CMS awarded 23 states a total of $307 million in bonus payments in FY 2014 through this program.

In full, the President's CHIP proposal cost $11.9 billion over 10 years. The Budget proposes increasing the tobacco tax, which would fully cover the cost of the CHIP proposals and greatly benefit public health. These programs have support from states and beneficiary groups and have contributed to health coverage gains among children; the President's proposals "in totality" should be enacted.

In addition, the President's budget includes a proposal to permanently extend the option for States to use Express Lane Eligibility (ELE) to enroll children in CHIP (as with Medicaid above). ELE allows states to use a quicker and more simplified process to determine or renew CHIP and Medicaid eligibility. This costs $1.2 billion over 10 years in total to extend the option in both Medicaid and CHIP.

C. Program Integrity

The President's budget includes an additional $201 million in new funding to prevent waste, fraud and abuse in Medicare and Medicaid. The Budget proposes both increasing funds for CMS's Health Care Fraud and Abuse Control program for program integrity activities and including $25 million in funds for program integrity activities for the health insurance marketplaces. This investment will yield $21.7 billion in savings over 10 years. These investments in anti-fraud activities should be supported as they promote fiscal integrity, foster proper program management, and save taxpayer dollars.

IV. AFFORDABLE CARE ACT (ACA) IMPLEMENTATION AND CMS PROGRAM MANAGEMENT

The President's budget request for CMS Program Management is $4.2 billion. This includes $544 million for improvement and management of the health insurance marketplaces. More than 11.4 million Americans have already used the marketplaces to purchase quality, affordable health insurance this year. Marketplaces also facilitate millions of Medicaid and CHIP enrollments and the additional investment in the marketplace operations is essential to ensure smooth operation of coverage, enrollment, and oversight and should be supported by Congress.

Notably, the Budget includes $50 million to facilitate the process of removing Social Security Numbers from Medicare beneficiary identification cards. This will help to protect seniors from identity theft and strengthen the Medicare program. There is bipartisan support for this proposal, and Congress should act to pass legislation to this effect.

V. PUBLIC HEALTH PROGRAMS

The FY 2016 Budget provides $83.8 billion in discretionary funding for HHS.

A. Food and Drug Administration (FDA)

The President's budget recognizes the importance of the FDA and its many critical public health missions. In overseeing the safety of our drugs, medical devices, and food, and regulating tobacco products, the FDA plays a vital role that touches the lives of Americans every day. The President's budget acknowledges the fundamental importance of the FDA and appropriately provides a 9 percent increase in its budget. Specifically, the President's budget includes $190 million in new proposed user fees to help support FDA's implementation of the Food Safety Modernization Act of 2011, and $18 million to support continued expansion and improvement of

FDA oversight of pharmacy drug compounding, as authorized through the Drug Quality and Security Act of 2013. It also includes $25 million to continue FDA's Medical Countermeasures Initiative, which was critical to the agency's response to the Ebola virus epidemic in West Africa. We commend the President for acknowledging the critical need for greater resources for these vital purposes.

B. National Institutes of Health (NIH)

The President's budget proposes funding NIH at a program level of $31.3 billion, or $1 billion above the FY15-enacted level. This would allow for 35,447 research project grants, of which over 10,000 would be new and competing awards. NIH research is critical in supporting American innovation efforts. For instance, NIH-supported advances have contributed to the development of as much as 20 percent of the drugs approved by FDA. Drugs resulting from NIH-sponsored work have also been shown to have a larger impact on public health than drugs developed without such support. Congress should support increased funding for NIH.

The President should be commended for his continued support of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative, which will improve our understanding of complex brain functions and their links to behavior and disease; and for the President's emphasis on research that will translate basic discoveries into new diagnostics and therapeutics. The President's budget also includes $200 million for NIH for the President's Precision Medicine Initiative, which aims to advance the development of treatments specific to the individual characteristics of each patient. This funding would allow NIH to launch a national research cohort of at least one million individuals who volunteer to share their genetic information and to expand cancer genomics research.

C. Centers for Disease Control and Prevention (CDC)

The President's budget proposes $11.5 billion to support various public health programs at CDC. This is an increase of $250 million above the FY15-enacted level (excluding the $1.8 billion in emergency resources to support Ebola response and preparedness that CDC also received in December 2014). CDC is the nation's lead public health agency – charged with monitoring, investigating, and resolving public health problems in the U.S. and abroad; and supporting activities to prevent such problems from occurring in the first place. Congress should support a strong investment in CDC's public health work.

Among other initiatives, the President's budget prioritizes support of reducing the spread of antibiotic resistant pathogens and improving appropriate antibiotic prescribing and use; expanding laboratory safety training and oversight; and preventing and stopping transmission of viral hepatitis-related illness.

D. Health Resources and Service Administration (HRSA)

HRSA is the principal agency dedicated to ensuring that underserved Americans have increased access to basic health care. The President's budget continues to recognize the importance of HRSA-supported programs, and their work in conjunction with ACA insurance

reform and coverage expansions, to ensure meaningful access to health care for our most vulnerable populations.

The President's budget includes a three-year extension of ACA mandatory funding for health centers to support the delivery of cost-effective and high-quality primary care services. Because of their current patient demographics and statutory mandate to locate in underserved areas or to serve underserved populations, health centers are well-positioned to become the health care homes for millions of newly-insured Americans. The Budget also expands and continues ACA mandatory funding for the National Health Service Corps (NHSC) through FY 2020, supporting primary care clinicians who agree to practice in rural and other underserved areas. Congress should support these investments in needed primary care capacity for the millions of Americans gaining affordable insurance coverage through the ACA.

As part of a workforce initiative that includes the extension of enhanced Medicaid reimbursement for primary care providers and support for NHSC, the President also requests funding for a Targeted Support for Graduate Medical Education program that will support residency programs administered by teaching hospitals, children's hospitals, and community-based consortia – with a focus on primary and preventive care. We applaud the President's attention to workforce policies to improve the supply and geographic distribution of primary care providers and other high-need specialists; however, we believe greater consideration should be given to the proposal's impact on children's hospitals.

E. Mental Health and Prescription Drug Overdose

The President's budget includes $151 million, an increase of $35 million over FY15 enacted levels, to continue support for a package of proposals to promote early identification of mental illness and improve access to mental health services among students and young adults, the President's "Now is the Time" initiative, administrated by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Budget includes $99 million in new investments to address prescription drug misuse, abuse, and overdose. This includes funding for CDC to support grants for all 50 states to improve their prescription drug overdose prevention activities – including improvements to state prescription drug monitoring programs (PDMPs) – and for SAMHSA to increase access to opioid addiction treatment services; equip and educate first responders about naloxone, a drug that can be helpful in reducing overdose deaths; and help State substance abuse authorities develop comprehensive prevention approaches. Congress should support both of these proposals.

F. Other Public Health Initiatives

The President's budget proposes extension of mandatory support for four proven/evidenced-based public health programs that expire this year: the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); Special Diabetes Program; Health Professions Opportunity Grants program; and Personal Responsibility Education Program (PREP). Congress should support extension of these programs and also continue support for the Family-to-Family Information Center program, which supports non-profit, family-staffed

resources to help families of children and youth with special health care needs and the professionals who serve them.

VI. WITNESS

The Honorable Sylvia Mathews Burwell
Secretary
US Department of Health and Human Services